Doctoral Portfolio in Counselling Psychology

By Alyson Griffin BSc, MSc

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'Solution Focused Practitioners' experiences of facilitating post traumatic growth during brief therapy'

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'Show the fly the way out of the fly-bottle' (Wittgenstein, 1958)

Alyson Griffin

ABSTRACT

It is understood that trauma is something that can affect people in life. Trauma is a term that is readily used to acknowledge the experience of someone exposed to an adverse life event. There are various psychological therapies that help individuals to overcome trauma experiences. The unique contribution of this study is that little is known about the way in which Solution Focussed Brief Therapy (SFBT) can help clients coming to terms with such an experience, because it can help to facilitate post traumatic growth. SFBT is strengths based and is part of the positive psychology movement, where there is more of an emphasis on client resilience, rather than alleviating distress. SFBT offers a different way of working to the approaches already being utilised in this field. The current study aimed to provide insight into the experiences of Solution Focused Practitioners facilitating post traumatic growth during brief therapy, using qualitative methods. The study explored the experiences of a homogenous sample of six Solution Focused Practitioners; all had worked with trauma and were using SFBT in their working practice. Responses to questions asked during semi structured interviews were framed by the setting in which the practitioners worked, because they all operated from a centre known to the researcher. However, despite the potential influence of the setting, the researcher gained honest insight into the application of SFBT to trauma. Semi structured interviews were conducted and the interviews were transcribed. Verbatim transcripts were analysed using Interpretative Phenomenological Analysis (IPA) and from this four main themes were found: (i) Who am I? – Becoming Solution Focused; (ii) A problem world where trauma exists; (iii) A positive cocoon where growth can occur; (iv) The longevity of the approach – a big fish in a small pond. Further exploration of these themes along with their subthemes is included in the paper. Research literature relevant to this study is discussed and implications for further research and practice are also taken into consideration.

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1. RESEARCH DOSSIER

1.1 INTRODUCTION

1.1.1 OVERVIEW

The purpose of this research is to explore the experiences of solution focused practitioners facilitating post traumatic growth during brief therapy. In total, six practitioners were interviewed and transcripts were analysed using Interpretative Phenomenological Analysis (IPA) (Smith & Osborn, 2003; Smith, Flowers & Larkin, 2009). The introduction offers some background information setting the context for the research, and possible reasons that might help to explain how Solution Focused Brief Therapy (SFBT) facilitates post traumatic growth in clients who have been exposed to trauma. Some of the existing literature in the field will be introduced and explored more fully in the literature review in order to position this study in relation to research that has already been conducted.

1.1.2 SOLUTION FOCUSED BRIEF THERAPY AND POST TRAUMATIC GROWTH

Linley and Joseph (2004) conducted research on post traumatic growth, due to the field of psychology being saturated with research that tends to focus on the negative aspects of human experience. Their work has contributed to a greater movement in this field because it has been recognised that attention needs to be paid to how a more positive way of being can be facilitated through therapy (Linley & Joseph, 2005). There are wider implications for psychologists in their practice (Joseph & Linley, 2006), because people experience trauma differently, where some individuals will want to take positive action using the experience of

trauma as a catalyst for change. This study argues that SFBT builds on client strength helping to facilitate growth for clients, building on the resources they already have in their pursuit of realisation (Grant et al., 2012).

Lewis and Osborn (2004) claimed that in the field of mental health, the dominance of the medical model results in a problem focused perspective; SFBT has emerged because, in contrast, it reflects a humanistic and egalitarian way of working with clients by changing the meaning of the problem and its experience. Research has been conducted on the assumptions grounded in this approach and it is understood that the construction of solutions is the focus, without a need to try and analyse problems by finding the antecedents and consequences of these (see Berg, 1995; De Jong & Berg, 1998; Gingerich & Eisengart, 2000; Miller, 1997), it is implied that having prior knowledge of a problem is not conducive in formulating a solution or in promoting growth.

Post traumatic growth as a phenomenon has been of interest to researchers since the 1990s, several psychometric tools have been developed to look at this further: the Post-Traumatic Growth Inventory (PTGI; Tedeschi & Calhoun, 1996) and the Stress-Related Growth Scale (SRGS; Park, Cohen & Murch, 1996). Joseph and Linley (2008) highlighted that most of the tools have undergone quantitative analysis because of the need to examine the measurable outcomes they produce, however despite this level of investigation a clear theoretical conceptualisation of what constitutes growth is lacking. This study will approach the notion of post-traumatic growth from a qualitative perspective because the experiences of a homogenous group of solution focused practitioners can provide rich and invaluable insights into their experiences of working with clients, where trauma has threatened their existence.

1.1.3 THE SIGNIFICANCE OF SOLUTION FOCUSED THERAPY WHEN WORKING WITH TRAUMA

There is something quite unique about the approach taken to trauma through SFBT. Gergen (1991) discussed social constructionism underpinning SFBT, the idea being that there is no fixed reality because it is argued there are multiple and intangible realities forming a social system. Language is one of the most influential factors shaping our social realities (Guterman, 1996). The SFBT practitioner explores the use of language to create meaning because they actively listen to what the client wants (past, present and future) and will engage with skills of paraphrasing and summarising to ask further questions creating a detailed account of emotions experienced, behaviours displayed, cognitive processes and interactions with others during times when ordinary daily activities in the clients preferred future are already happening (McKergow & Korman, 2009). The practitioner will gradually develop the client's utterances in relation to what they want, choosing to only acknowledge what they do not want without interpretations made about the client's world underpinned by theoretical assumptions (McKergow & Korman, 2009). Through SFBT clients are encouraged to take time to consider what the experience means to them because it is believed that realities are always "under construction", the SFBT practitioner can facilitate the reality of a traumatic experience by helping clients to challenge their perspective (Lewis & Osborn, 2004), putting it into the broader context of life.

One of the factors that can hinder a client's progress is feeling disabled when talking about their experiences; the SFBT practitioner can enable the client to construct solutions through the discourse that takes place offering the practitioner an opening into the client's world (Cavanagh & Grant, 2010; de Shazer, 1988; O'Connell, 1998). It is deliberate on the part of the SFBT practitioner not to engage in a rumination cycle with the client because this draws

attention to the client's deficits, which are counterproductive for growth (Grant et al., 2012). Instead the SFBT practitioner will engage in a flexible style of conversation weaving dialogue between 'problem/solution'; 'past/present'; 'individual/system'; 'goal/strategies'; and three different types of discourse all discussed by O'Connell, (1998), highlighting to the client they have the ability to solve problems (change); there will be a focus on interventions that can link current change processes to goals the client wants to achieve (solution); a collaborative engagement helps the client to take ownership of their goals by monitoring their own progress (strategy) (O'Connell, 1998).

Despite the positive aspects of SFBT highlighted so far, it has been criticised by feminist scholars. Dermer et al., (1998) argued that the approach does not take into consideration the expectations of women in society; the assumptions related to myths about a household involving a pair of adults and their children (nuclear family); and the impact of a larger system on a family unit. Furthermore, within this argument Hudson and O'Hanlon, (1991) argued that SFBT is 'action oriented' rather than 'explanation oriented' influencing change occurring as a result of behaviour rather than from insight and explanation, for example, through cognitive restructuring (Dermer, Hemesath, & Russell (1998). A feminist perspective also favours the process of self-reflection where a practitioner should engage in an active process of exploring their values and beliefs, working through personal issues stemming from a wider system of values (Dermer, et al., (1998). This might explain why some SFBT practitioners may choose to commence their therapeutic career in another orientation by accessing personal therapy during their training, progressing onto SFBT once they have gained more experience and are confident in the application of specific techniques.

1.1.4 OTHER APPROACHES USED TO TREAT TRAUMA

Spermon, Darlington and Gibney (2010) argued that there have been several attempts to try and define trauma by comparison to the life experiences people have, not resulting in further complications; a number of therapies have tried to respond to the various trauma presentations. It has been observed that over time there has been movement in the field of trauma therapy reflecting evolvement in our understanding of what might be required. Bradley, Greene, Russ, Dutra and Westen (2005) discussed therapies relevant to this field where the traditional analytic approach was the first to offer support for this issue; psychodynamic therapy stemmed from this focussing on the intrapsychic, developmental and relational therapies; and CBT evolved from a different school of therapy gaining recognition due to the strength of its evidence base. Spermon et al., (2010) highlighted more recent therapies, including Dialectical Behaviour Therapy (DBT).

There is a need for a wide variety of therapies that can treat an individual who has experienced trauma, specifically due to an argument posed by Ehlers and Clark (2000) where it is recognised that PTSD is a common reaction to trauma and has been widely experienced by many people, supporting the need for psychological intervention. Recommendations about the type of treatment that is most effective for PTSD is outlined in good practice guidelines for adults, children and young people receiving trauma focused psychological treatment (Trauma Focused CBT and EMDR) by NICE (2005) (appendix 10). Despite the significance of research findings documented in recommendations like the NICE guidelines, there is still a lot to be learned about which are the most effective at treating PTSD (Taylor et al. 2003), and equally the approaches that are conducive to someone's recovery when they have not developed symptoms associated with this disorder.

There have been many reviews carried out on evidence based treatment (Roth & Fonagy, 2005) where Cognitive Behavioural Therapy (CBT) and Eye Movement Desensitisation and Reprocessing (EMDR; Shapiro, 2001) are the empirically supported treatments for post-traumatic stress disorder (PTSD), especially as they are the gold standards of practice for NHS workers. Despite the acceptance of these treatment approaches by the NHS it is also important to recognise that individuals exposed to trauma can differ widely in their response, pointing to the significance of perception and personal meaning attached to these experiences (Ehlers & Steil, 1995); this implies that some individuals may respond better to another type of treatment approach with less of an emphasis on the exploration of the trauma experience. SFBT has an important part to play because the practitioner will always work with a client's frame of reference helping the client to develop a constructive, realistic and useful perspective (Visser, 2012), with movement into a paradigm of solutions.

1.1.5 THE GAP IN CURRENT RESEARCH

Research conducted on SFBT so far has shown promise for its effective use in response to an array of client issues, for example: eating disorders, addiction, anxiety and perfectionism (Jeffrey, Guterman & Shatz, 2012). Empirical support that would provide a strong evidence base informing the practice of SFBT through clinical guidelines is lacking (Kim, 2014). SFBT has therefore been criticised for failing to address this (Eckert, 1993; Fish, 1995, 1997; Miller, 1994; Shoham, Rohrbaugh & Patterson, 1995; Stalker, Levene & Coady, 1999). There are some benefits to evidence based research and as stated by Kazdin (2008) "the unifying goals of clinical research and practice are to increase our understanding of therapy and to improve patient care" (p. 151). There is a growing interest in SFBT and a developing clinical research field (Lehmann & Patton, 2011). Evidence based practice is important because it shows what treatment methods are the most effective, this is also demonstrated through the

randomised control trial and the meta-analysis (Mills & Hulbert-Williams, 2012); examples of which are discussed further in the review. It is important that practitioners have relevant evidence on which they can base their practice; hence why the guidelines offered by the National Institute for Health and Clinical Excellence (NICE, 2005) are the gold standard. Outcome studies have attempted to capture the essence of SFBT, but this has proven difficult because of the variability in SFBT practice; attempts have been made to try and look at the core components to increase treatment fidelity (Beyebach, 2000), discussed further in the literature review.

1.1.6 AIMS AND OBJECTIVES

There is a gap in the research literature focussing on SFBT in relation to trauma and the role of the SFBT practitioner in the field of psychological trauma work has been largely ignored to date; this research intends to try and bridge some of the gaps in the existing research literature. The use of Interpretative Phenomenological Analysis (IPA) will provide valuable insight into the personal experiences of the practitioners, their personal view of trauma, what meaning the term post traumatic growth has for them and how they have experienced facilitating this. The study may highlight potential areas of research in relation to clients and how they have experienced SFBT in helping them to overcome trauma where they have been provided with the opportunity to develop post traumatic growth; insights like this may offer some indication of the ways in which we can help clients to move on in a way that is constructive for them. From a qualitative perspective, this study aims to explore the SFBT practitioners' experiences of facilitating post traumatic growth during brief therapy. Due to the nature of this research there will be more of an understanding of what the practitioner brings to the client's world when trauma has been experienced. Whilst there is currently a lack of volume of research, this does not equate to a lack of empirical support, in that the

little amount of research that has been amassed has been supportive of the efficacy and effectiveness of SFBT.

1.1.7 RESEARCH QUESTION

SFBT is effective for trauma work because it can help clients come to terms with such an experience. One way in which it is effective is that it promotes post traumatic growth (Bannink, 2008), but we do not know the precise psychological mechanism that the promotion of post-traumatic growth is realised in therapy, hence, why the practitioners need to be asked. The research question for this study is as follows:

"What are the experiences of solution focused practitioners' in the facilitation of post-traumatic growth during brief therapy?"

1.2 LITERATURE REVIEW

1.2.1 INTRODUCTION

The purpose of this review will be to present the empirical evidence relevant to experiences of SFBT practitioners facilitating post traumatic growth during brief therapy. This literature review will present the notion of trauma and post-traumatic growth, how SFBT can help to facilitate post traumatic growth, how trauma is viewed from different therapeutic orientations and consequently worked with and what SFBT can offer to this field taking into consideration implications for the application of SFBT to practice. This review might help to position the study in the wider field of literature whilst highlighting any potential gaps that can be addressed with further research, because at present it is overlooked as an approach that could be employed for work with trauma.

1.2.2 HOW SUITABLE ARTICLES WERE IDENTIFIED

Relevant research articles were identified through a search using electronic databases hosted by EBSCO, (PsychINFO, Web of Knowledge, Science Direct) and Google Scholar. Key words included: trauma, solution focused therapy, trauma interventions/treatment, brief therapy, post-traumatic growth, and post-traumatic stress disorder (PTSD). No specific dates limiting the search were included and Zetoc alerts were used to keep up to date with new publications. Research articles were selected for this review if they were examining SFBT, trauma and post-traumatic growth.

1.2.3 TRAUMA?

It is widely recognised that experiencing trauma is something that is part of human life; it is inevitable that people will be faced with horrendous events leading to fear and a sense of helplessness (Bannink, 2008). The role of trauma was discussed by Neocleous (2012) with attention drawn to how the term influences behaviour; society has become desensitised to the notion of trauma because the term has been readily used to describe all kinds of events on a trauma spectrum, from the catastrophic to the most mundane (Neocleous, 2012). To reflect the changes over time in the prevalence of trauma experiences and developments in the psychiatric field, the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2013) has been revised five times and now includes the term: Post Traumatic Stress Disorder (PTSD); established as an independent diagnostic category. The diagnosis of PTSD is outlined in the table of criterion in appendix 11 taken from the electronic version of DSM-5 created by the American Psychiatric Association (2013). The recognition of PTSD has wider implications in offering people an understanding and a concrete definition (Neocleous, 2012), when experiencing symptoms associated with this disorder. This could be one of the possible explanations why most research out of all of the mental health classifications has been conducted on the diagnosis of PTSD, because it is well defined, clinically measurable and high risk outcomes are associated.

PTSD is accepted as something that is a "normal" part of the aftermath of trauma and symptoms could include for example; 're-experiencing of the event', where the individual replays the experience cognitively to try and come to terms with it (Ehlers & Clark, 2000). Bannink (2008) noted how some people might feel relatively normal after an atypical experience such as trauma, whereas others can go on to develop PTSD, but with some delay

in the development of symptoms. On a positive note, Bannink (2008) argued that not everyone exposed to trauma experiences unwanted psychological outcomes. This implies that some people may have higher levels of resilience or are better equipped to cope in the face of adversity. The individual's response to the traumatic experience will also be influenced by the type of trauma that it is, and by individual differences in the way the event is appraised. These will now be discussed.

'Simple' and 'complex' trauma was identified by Herman (1992) who suggested that these different types of trauma can have different implications for the individual, especially when trying to resolve associated symptoms. Herman (1992) argued that 'simple' trauma refers to the experience of an isolated event shattering the individual's sense of safety in the world; and 'complex' trauma refers to trauma experienced on multiple occasions, like the trauma that a prisoner of war is subjected to. The implications for the individual in terms of the type of trauma experienced was explored by Zlotnick et al., (2008) who argued that exposure to a potentially traumatic event (PTE), for example assault and rape, is associated with a higher level of psychiatric morbidity (increased vulnerability of developing PTSD), than having no experience of trauma; and exposure to PTE at any time in life is associated with psychiatric morbidity. The mental health of individuals subjected to complex trauma was explored in a study by Kaltman, Krupnick, Stockton, Hooper and Green (2005) examining the 'psychological impact of types of trauma among college women' 125 college sophomore women participated; two thirds of these participants were white. Due to gender bias and cultural differences the generalisation of the findings is somewhat limited. However, having multiple experiences of sexual related trauma, for example re-victimization, was associated with an increased risk of developing negative mental health outcomes in the future. Furthermore, they recommended that adolescence is a significant developmental stage for

practitioners because the application of trauma related interventions at this time can prevent negative mental health outcomes and deleterious adult behaviours from occurring in the future or in the aftermath of trauma (Kaltman et al., 2005). Most importantly the participants in this study were assigned to 'mutually exclusive trauma groups' based on their responses to a telephone interview (Kaltman et al., 2005), suggesting the way the participant processed their experience had further implications for their involvement in the study thereafter and whether they participated further in a face to face interview with one of the researchers.

Evidence suggests there are individual differences in the way a traumatic experience is emotionally and cognitively processed contributing to the development and maintenance of PTSD (Clark & Ehlers, 2004; Ehlers & Clark, 2000; Foa & Kozak, 1986; Smucker, 1997). The way in which the individual interprets and appraises trauma resulting in the subsequent memory contributes to persistent PTSD (Gozalez-Prendes & Resko, 2012). These internal appraisals may be understood as the 'subjective' component of the trauma experience, as defined by Allen (1995) and the 'objective' component would therefore be exposure to trauma, highlighting why some people might find a trauma experience more difficult to cope with than others (Allen, 1995); the level of resilience an individual has results in beliefs about the self, leading to further implications for ability to cope with adversity. Foa and Riggs (1993) and Foa and Rothbaum (1998) argued that PTSD is characterised by two flawed beliefs: *firstly* the self is seen as incompetent, and *secondly* the world is seen as threatening and unsafe. These findings are supported by Dunmore, Clark and Ehlers (1999) who examined factors contributing to the onset and maintenance of PTSD in 92 assault victims and found that holding flawed beliefs resulted in avoidance and fear of a world seen as dangerous, and possessing a critical view of the self diminished ability to cope resulting in feeling overwhelmed and destabilised by trauma. The importance of the individual meaning

attached to trauma was discussed by Gruen, Folkman and Lazarus (1988) who argued that the extent to which an event that is harmful or has the potential to be harmful to the individual and their environment is dependent on the significance of the experience; based on the individuals coping resources and personal agenda, for example goals and beliefs.

The meaning of trauma to the individual is difficult to measure. There has been some attempt to try and explore how a trauma experience is assessed through empirical studies and the creation of psychological models explaining the process, but what is consistent throughout is the experience of unpredictability and uncontrollability. These factors are central to whether or not a person develops PTSD (see Davidson & Foa, 1993; Foa, Zinbarg & Rothbaum, 1992; Jones & Barlow, 1990). These factors can be present at different stages throughout the trauma experience, and if broken down into parts as suggested by Williams and Poijula (2002) into 'pre event', 'event' and 'post event' we can begin to understand how PTSD might develop when also taking into account the unpredictability and uncontrollability of the trauma. Ehler and Clark (2000) recognised that individuals who come to terms with trauma naturally are able to see the trauma as something that happened in a specific time frame, not necessarily allowing it to affect how they live the rest of their life. Furthermore, Antonovsky (1987) and Kobasa (1982) looked at other important factors that might affect the feelings evoked during a traumatic experience and consequently the response to it. They argued that having an internal locus of control, where a person recognises they control what happens to them from within; having a sense of confidence in ones abilities; and acceptance that trauma can evoke meaning developing hardiness, are all important factors that need to be taken into consideration and nurtured through therapy. If the assumptions held about life and the self are positive, for example, viewing the world as a good place and feeling entitled to good things (Janoff-Bulman, 1992); therapy can help to foster these. A traumatic event can cause someone to feel psychologically crushed where there is the potential to no longer feel in

control of what happens (Williams & Poijula, 2002), but equally positive assumptions about life serve as a means of regaining control forming foundations for growth. Recommendations suggest the individual needs to accept the impact of trauma on them personally because it can offer the opportunity to try and find a new purpose in life (Williams & Poijula, 2002); facilitated through therapy, if the person is struggling to identify the potential for opportunity themselves.

1.2.4 POST TRAUMATIC SUCCESS/GROWTH

It is understood that reactions to trauma are different for everyone and the famous statement made by Nietzche (1998) 'that which doesn't kill me makes me stronger' is something that most people are familiar with. In recent years there has been several researchers interested in whether trauma can serve as a catalyst for positive life changes; Tedeschi, Park & Calhoun (1998) coined the term 'post traumatic growth' to capture their own experiences of this from witnessing the positive changes that occurred on a psychological level in their patients who had encountered traumatic life events. O'Hanlon (1999) introduced the term 'posttraumatic success'; similar to posttraumatic growth, further validated by Seligman (2002) the founder of positive psychology, who emphasised the difference between 'learned helplessness' and 'learned optimism' with very different implications for the individual in terms of how they move on from trauma through the perception they have.

When trying to define what post traumatic growth means the focus tends to be on how the individual's personality might have changed, because of the impact upon cognitions and emotional response (Jayawickreme & Blackie, 2014); the domain of personality psychologists, who as argued by Fleeson (2012) are concerned with how these types of

processes impact upon wellbeing. However, despite the recognition of the fact that personality can change after a trauma experience, the construct of post-traumatic growth despite evoking great interest to researchers in the last decade, has not been without controversy. There is no theoretical conceptualisation of what might constitute growth following adversity (see, Joseph & Linley, 2008) and as argued by Jayawickreme and Blackie (2014) the availability of retrospective reports concerning post traumatic growth remain questionable, the validity of the construct has been questioned by researchers who have noted that methodological limitations have not been addressed, and the present findings clarifying what it is have been over interpreted. Tennen (2013) argued that despite the various conceptualisations of post-traumatic growth, to date there is not a concrete definition that really epitomises what it is (Tennen, 2013). Tedeschi and Calhoun (2006) attempted to capture what post traumatic growth involved by measuring the positive outcomes reported by those who experienced trauma through the Posttraumatic Growth Inventory (PGGI). As discussed by Jayawickreme and Blackie (2014) in their review of this measure, it was observed that post traumatic growth was likely to occur in five distinct domains – a greater appreciation for life; more intimate social relationships; heightened feelings of personal strength; a greater engagement in spiritual questions; and the recognition that there are new possibilities in life. Growth was seen as a process leading to a greater appreciation for life over a longer period of time and was unique to previous findings that might have focussed more on the negative aspects of trauma (Jayawickreme & Blackie, 2014). Similarly to the research conducted through the application of the PGGI, Joseph and Linley (2005) recognised that post traumatic growth is not too dissimilar from what could be defined as psychological wellbeing (PWB; Ryff, 1989). Founded by Ryff (1989) came the argument that PWB consisted of an increase in specific domains, for example; self-acceptance, purpose in life, autonomy and positive relations with others and environmental mastery. All of the

findings obtained in relation to the PGGI and PWB demonstrate that positive changes in various domains exist and are important to acknowledge.

What is significant and as highlighted by Jayawickreme and Blackie (2014) is that trauma is not an essential part of post-traumatic growth, but rather the life event which proves difficult to assimilate can facilitate positive wellbeing as an independent factor. The process that an individual has to go through in order to reach post-traumatic growth was likened to that of the rebuilding that takes place after an earthquake by Jayawickreme and Blackie (2014). If the individual avoids the experience completely by not taking the opportunity to look for positive change, instead assimilating the experience into prior beliefs about the world, post-traumatic growth will not occur (Tedeschi & Calhoun, 2004). If the individual tries to assimilate the experience in a negative way they might become more susceptible to feelings of hopelessness, thus developing symptoms of PTSD (Joseph & Linley, 2005). The revision of a life narrative thus far can be the catalyst for making sense of the experience (Pals and McAdams, 2004), hence why it is argued that therapy can provide a place in which the narrative around the trauma experience can be explored further.

1.2.5 RECENT DEVELOPMENTS IN THE TREATMENT OF TRAUMA

Trauma work has been discussed in terms of crisis intervention (Greene, Lee, Trask & Rheinscheld, 2005), including clients experiencing psychiatric emergencies (Booker, 1996); clients with depression (Lee, Greene, Mentzer, Pinnell & Niles, 2001); thought disorders (Hagen & Mitchell, 2001); and clients experiencing suicidal ideation (Hawkes, Marsh & Wilgosh, 1998; Rowan & Hanlon, 1999; Sharry, Darmody & Madden, 2002; Softas-Nall & Francis, 1998). A vast amount of research has been carried out on the different approaches

used for the treatment of PTSD. However, as it is beyond the scope of this paper to cover all, the main theories are summarised by Gonzales-Prendes and Resko (2012) in table 1.1 on the following page.

Only some of the theories are explored in more depth, namely Brief Psychodynamic Psychotherapy, where conflicts that arise on an emotional level caused by the experience of a traumatic event are the focus of treatment, these conflicts might help to unravel early unresolved life experiences (see Horowitz, 1997; Krupnick, 2002); under the umbrella of Cognitive Behavioural Treatment is Exposure Therapy, Anxiety Management and Cognitive Therapy; this framework is most effective in helping someone to come to terms with the trauma experience, at odds with pre-existing schemas (Jaycox, Zoellner & Foa, 2002); a type of Exposure Therapy is Eye Movement Desensitisation and Reprocessing (EMDR; Shapiro, 1989), which is a means of desensitising a client to traumatic material through eye movements (Shapiro, 1995).Whilst there is little evidence to support the use of SFBT as an approach to work with trauma, the potential that it can offer to the field of trauma work will be explored.

Table 1.1. Trauma approaches, theoretical assumptions, application and critique

APPROACHES	THEORETICAL ASSUMPTIONS	APPLICATION AND CRITIQUE
COGNITIVE BEHAVIOURAL THERAPY	There are two theoretical orientations explaining the development of fear and how it is processed: Learning Theory (Mowrer, 1960; Wolpe, 1990) and Emotional Processing Theory (Clark & Ehlers, 2004; Ehlers & Clark, 2000; Foa & Kozak, 1986; Foa, Steketee & Rothbaum, 1989; Hembree & Foa, 2004; Rachman, 1980). Learning Theory is associated with a behavioural perspective focusing on changing behaviour through environmental cues. Mowrer argued that emotions are learned in two parts: classical conditioning (anticipatory fear) and operant conditioning (avoidance of fear creating secondary reinforcement of avoidance behaviour).	• Traditional learning theories offer an explanation about the acquisition of fear and the process of avoidance typically seen in PTSD. • Criticism is given for not providing a full explanation of PTSD, including the full spectrum of associated symptoms. In addition to this is the inability to account for generalisation of fear across different situations and the failure to include thoughts, appraisals and meaning concepts associated with traumatic memory.
	Emotional Processing Theory provides a framework allowing for analysis and explanation of the onset and maintenance of PTSD. Foa and Kozak (1986) argue that emotions are representations of information structures in the memory helping the individual to escape or avoid perceived threat.	• Foa and Kozak (1986) defined emotional processing as the activation and modification of the memory structure underlying the fear response – access to the memory of the event is created reactivating the fear through exposure and secondly helping the individual to access new information that is incompatible with maladaptive information.
EXPOSURE THERAPIES	Avoidance is a central mechanism for the maintenance of anxiety disorders including PTSD. Exposure is perceived as essential to overcoming fear. Exposure therapies focus on the activation of affective and cognitive processes associated with trauma to facilitate healthy processing of trauma. These types of therapies tend to differ in the level of contact and the intensity of exposure to stimuli that is causing the fear.	Prolonged Exposure (PE) – imaginal exposure consists of repeated imaginal reliving of the traumatic memory along with an in-vivo exposure exercise to confront trauma (Hembree & Foa, 2004).There are four integral components: education, breathing, retraining, imaginal exposure and in-vivo exposure between sessions to cues associated with trauma (Hembree & Foa, 2004). • Virtual Reality Exposure (VRE) – integrates real time computer generated stimulation that responds to head and body motions, other sensory input (sounds) and visual displays creating a virtual reality allowing for immersion in feared situation (Parsons & Rizzo, 2008; Rothbaum, Ruef, Litz, Han & Hodges, 2003).
EMDR	Developed by Shapiro (1989) to reduce distress of traumatic memories. The process involves a three-pronged approach addressing the etiology of a trauma experience (past), the triggers (present) and development of templates to cope with upsetting events (future) (Shapiro, 2007).	Direct questions are used to desensitize the client through brief imagined exposure to the traumatic memory (Shapiro, 2001). The client receives bilateral stimulation involving therapist-directed saccadic eye movements, asking the client to follow movement with eyes (Shapiro, 2001). This approach is controversial because an understanding of EMDR's treatment mechanism is lacking; additional research is needed (Gonzalez-Prendes & Resko, 2012)

Research has shown that the problem with existing interventions is they do not take into account individual differences; something that could be gained by asking clients about their experiences of therapy helping them to overcome trauma (Mills & Hulbert-Williams, 2012). Any intervention that is used to treat a specific issue such as trauma will be informed by the underlying cause (Schottenbauer, Glass, Arnkoff & Gray, 2008) highlighting the importance of evidence based practice which governs how clinical work is carried out. In practice, not all practitioners rely on evidence-based recommendations, choosing instead to make their own decisions about what treatment they deliver (Newnham & Page, 2010). The autonomy of the client and the practitioner is most important because it allows them to draw on their experiences of what they believe could work most effectively. Furthermore, there is more substance to be added to the argument against the use of exposure based therapy because there is the potential for symptoms to be exaggerated, highlighting one of the main reasons for practitioners' reluctance to apply it (Becker, Zayfert & Anderson, 2004). It is further noted that whilst there is the acknowledgment that certain trauma diagnoses, like PTSD, require intervention, there is a lack of research looking at the experiences of those who have experienced trauma and not developed PTSD (Briere, 2004). Hence, why there is a need for the client perspective (which could be gained through further research) to take priority in the science of psychological intervention (Stewart & Chambless, 2010); information like this would inform professionals about why some of the methods to treatment are simply not as effective as others used in working practice (Mills & Hulbert-Williams, 2012) and we would know more about individual differences and about routes to facilitating positive adjustment.

1.2.6 THE DEVELOPMENT OF SOLUTION FOCUSED BRIEF THERAPY AND ITS RELEVANCE TO TRAUMA

SFBT was established at the Brief Family Therapy Centre (BFTC) by de Shazer and colleagues in 2007. One of the most significant aspects of SFBT is that it operates at a level where there can be interplay between individual differences and the therapeutic approach; it allows for individual strengths to take effect because of the emphasis on the resources people already possess and how these can be applied to the change process (Corcoran & Pillai, 2009).The main aim of this therapeutic approach is the provision of a collaborative experience where the client is encouraged to move forward in life by achieving their goals, all of which take place through a process of psychotherapeutic change (de Shazer et al, 2007). The approach is different to others because it stems from the suggestion that there are inconsistencies which can be uncovered in problematic behaviours (de Shazer, 1984); and it is in stark contrast to approaches basing their assumptions on the medical model, because SFBT takes a 'non-pathological', 'goal oriented approach' to therapy focusing on the construction of solutions rather than looking in depth at why the problem developed (Walter & Peller, 1992). Bannink (2007) in his article: 'Posttraumatic Success: Solution Focused Brief Therapy argued that the focus should shift from impossibilities to possibilities and offered recommendations about the replacement of training on diagnosis and treatment of psychological issues with training in SFBT. Listening to the experiences of practitioners' whose ability to help clients to overcome traumatic experiences that did not lead to the development of PTSD could provide valuable insight into how the model builds on the survival of those experiences.

Most importantly it is essential for the individual to learn how to process trauma in a way that is effective for them because as identified in an argument by Siegel (1999) studies of early trauma and neglect have shown that structures in the brain can become severely affected by trauma, resulting in long lasting problems with the ability of the brain to adapt to stressful situations. Individuals need to develop new neural integrative links that will remain into adulthood, the brain retains the ability to reshape developing properties that help us to learn from new experiences encountered (Siegel, 1999). In helping a person to reshape their developing properties learning from new experiences, it might be helpful to focus on levels of resilience, which is something SFBT practitioners nurture through therapeutic interactions. O'Connell, Palmer and Williams (2012) explored the potential benefits that can be derived from these therapeutic interactions consisting of principle elements demonstrated through 'change talk', consisting of: 'competence talk' where the practitioner highlights strengths and qualities needed to solve problems (de Shazer, 1988) and the clients ability to cope is reinforced (O'Connell et al., 2012); 'exception talk' where the practitioner engages the client in a process of finding exceptions, the occasions when the problem was being managed better or was not even happening at all; and 'context-changing talk' where the practitioner helps the client to put the problem into a different frame, to make it more solvable (O'Hanlon & Wilk, 1987).

SFBT is based on a set of assumptions recommending how it should be applied in context and the specific techniques that can be employed to try and evoke positive changes in the client's life (Hawkes et al., 1998; Walter & Peller, 1992). Trepper et al., (2012) summarised the basic tenets of the approach emphasising work on the clients' understanding of their concerns and what they might want to change. The basic tenets include, for example; focusing on the clients' desired future rather than past problems or current conflicts and

utilisation of conversational skills encourage the client to build solutions, rather than making attempts to diagnose and treat the problem bringing the client to therapy. In addition to the basic tenets of the approach offered by Trepper et al., (2012) a treatment manual developed to standardise the implementation of SFBT and increase treatment fidelity (discussed further in the review) was developed by the Research Committee of the Solution Focused Brief Therapy Association (SFBTA) identifying three components as representing the whole approach of SFBT: use of conversations centred on client concerns, conversations constructed on co-constructing new meanings surrounding client concerns; use of specific techniques to help clients to co-construct a vision of a preferred future and to draw upon past successes and strengths to help resolve issues (Trepper, Dolan, McCollum & Nelson, 2008), some components may be unexpected because there is the assumption that SFBT avoids client concerns, but how can the techniques be relative to the client without some understanding of what is going on. Other reviews conducted by de Shazer and Berg (1997) and Gingerich and Eisengart (2000) identified the following techniques and core components of the approach, which are frequently applied in sessions with clients: using the miracle question; scaling; scheduling a break and giving the client a set of compliments; assigning homework tasks; looking for strengths and resources; setting goals; and looking for exceptions to the problem. Achieving a deep understanding of the problem is not considered to help the client to become more stabilised; supported by Byrd-Craven, Geary, Rose and Ponzi (2008) who found that discussing problems at length can lead to an increase in the stress hormone, cortisol, which is implicated in depression and anxiety. SFBT discourages talking about problems, hence why one of their techniques includes 'problem free talk' (O'Connell, 1998), so it could be inferred that as an approach it may help to reduce someone's susceptibility to depression or anxiety because it does not advocate exposure to the emotional vulnerabilities that might be related to talking about these psychological issues.

Fostering resilience is perhaps more important considering it is found to be the most common outcome following a traumatic event, as argued by Bonanno, Rennicke & Dekel, (2005); resilience is arguably something that falls under the umbrella of post-traumatic growth. Even though research has been conducted on the positive outcomes that can be experienced after a traumatic experience, perhaps there is also a need to focus on what can be done to foster resilience as an independent factor (Bonanno, 2005), with or without the presence of post-traumatic growth per se, which is dependent on various factors already explored.

SFBT is located alongside some of the major psychological theories already established in explaining and underpinning interventions for trauma. It could be argued that one of the strengths of this approach is that it is not overcomplicated with theories that may cloud the intention of the approach, due to its minimalistic aim following Occam's principle that, 'it is vain to do with more what can be achieved with fewer' (Shennan & Iveson, 2012). Research has been conducted by Shennan and Iveson (2012) on SFBT over a period of time forming several conclusions. One of these related to the Occam principle which is now used as a central philosophy guiding practice, instigating the removal of things that were unnecessary making more room for creativity in sessions. One of the ways this was applied practically was in the decision to remove the categorisation of a client- therapist relationship; this served to evoke change in how therapy was perceived and consequently how therapy was carried out leading to further refinement in working practice like: removal of the emphasis on setting tasks for completion and becoming more focused on the conversations that took place (Shennan & Iveson, 2012). Conversations and the language used in SFBT are important and bring attention to the underlying social constructionist underpinnings of the approach. Language is seen as a tool that can help clients to construct a new/better version of reality (Franklin, 1998). The way situations are perceived in relation to worldview is linked to use of

language and as argued by Duncan, Solovey & Rusk, (1990) a client's worldview can have resounding effects on the type of therapy that is employed, these factors need to be taken into consideration when trying to work from a specific theoretical orientation because interventions will be aligned to that position. One way of achieving this is to focus on the client's use of language; the essential component of SFBT, to determine how they construct their reality and relate to the people who might be in their system. The importance of the use of language in SFBT is demonstrated through recent experimental studies where it is recognised that this approach relies on the strategic use of language, which is unique to SFBT because it facilitates change in the client's perception (Tomori & Bavelas, 2007), with the aim of enabling the client to look at the trauma experience from a different perspective. Communication researchers McGee, Del Vento & Bavelas, (2005) described the process as a means of creating common ground for therapy; the client becomes actively involved in a process of discovery, constructing an identity that is in line with the positive qualities needed to lead a more fulfilling life.

In addition to the important points that have been discussed about the use of language it is also necessary to highlight how the approach helps clients to develop or increase their levels of self-awareness. Through the process of therapy clients acquire new knowledge leading to development of the appropriate skills that might be relevant to their culture and matched to their views on the world (Lee, Draper & Lee, 2001); one of the strengths of SFBT is its sensitivity to culture where clients are empowered to question their own assumptions without the influence of an imposing view from the therapist. Part of this process is the awareness of the SFBT therapist who has to recognise and evaluate their own worldviews taking into consideration how these could have the potential to influence a client who might be in a vulnerable state (Martin, Garske & Davis, 2012). It is believed that once clients are more

accepting of their position in the world this can help them to make more effectual decisions about how they choose to live their life, which supports a recent evolution in science, which is more concerned with client strength and resilience (Seligman & Csikszentmihalyi, 2000), rather than with the negative aspects of trauma. SFBT could therefore be considered to be ahead of some of its therapeutic rivals in that it supported this notion right from the start and was established on this very basis due to the importance of the clients' positon in their world.

1.2.7 IMPLICATIONS FOR THE PRACTICE OF SOLUTION FOCUSED BRIEF THERAPY

In the United Kingdom, the National Institute for Health and Clinical Excellence (NICE) issues evidence based guidelines for NHS practitioners regarding treatments and interventions that are recommended. As argued by Shennan and Iveson (2012) NICE need to be convinced that SFBT can be effective with specific client groups and across the board, NICE prioritise randomised controlled trials (RCTs) an important indicator of effectiveness. However, such research is often impractical, and lacking in ecological validity, not necessarily useful in the mental health field populations (Shennan & Iveson, 2012). Hence why a lot of the research conducted on SFBT has been through practice based research looking at outcomes in the work place, implying greater ecological validity. The issue of fidelity is important to SFBT and is defined as "the adherence of actual treatment delivery to the protocol originally developed" (Orwin, 2000, p. 310). The concept of treatment fidelity to SFBT is relatively new and there are a number of reasons why it is important (Lehmann & Patton, 2011). Treatment fidelity is an ongoing issue with SFBT. Practitioners now have the benefit of a manual to guide implementation (Trepper et al., 2012). However, one of the remaining limitations is the lack of diagnostic structure. It is unable to provide a diagnosis for

individuals seeking therapy, there are problems measuring efficacy (Trepper, et al., 2012), through improvement in scores on psychometric tests. Some dedicated SFBT practitioners could argue that SFBT as an atheoretical approach does not need to demonstrate an evidence base, or that as a postmodern approach, it does not lend itself to the rigors of empirical investigation (Trepper et al., 2012), as argued by Corcoran & Pillai, (2009). Conversely, it is recognised that if SFBT is to become a model of practice that can be taught and researched it is important to have an instrument that can test how the approach is working in practice. A number of instruments are available (see Chevalier, 1995; De Jong & Berg, 1997; Fiske & Zalter, 2005); none have undergone rigorous psychometric testing. Where the instruments have demonstrated positive outcomes, it is questioned as to whether these have occurred as a result of the use of the model or due to 'therapist effects' (Lehmann & Patton, 2011).

Gingerich and Peterson (2012) reviewed all available controlled outcome studies of SFBT up to 2012 in an evaluation of its effectiveness. Two of the meta-analytic reviews that were comprehensively discussed in their review are as follows:

1) The first meta-analytic review was conducted by Stams, Debovic, Buist & Vries, (2006) included 21 studies with a total of 1,421 participants. There was a small to medium effect size (d = .37), with somewhat larger effects in more recent studies and in studies of behavioural problems versus marital or psychiatric problems. They found that SFBT effects were no larger than other approaches, but the outcomes occurred sooner. The validity of the review was compromised because some non-experimental studies were included and other controlled studies available at the time were left out.

2) A second meta analytic review was conducted by Kim (2008); part of the criteria set for this review was to look at the core components of SFBT to measure effectiveness, these included: therapists use of the miracle question; use of scaling questions; consulting break and giving the client a set of compliments; assignment of homework tasks; looking for strengths or solutions; goal setting; looking for exceptions to the problem. The study used Stock's (1994) six broad coding categories: report identification, setting, subjects, methodology, treatment, and effect size and Hierarchical Linear Modelling (HLM) was employed because a meta-analysis is viewed as hierarchical data set with sample subjects within each primary study at first level and second level (Hox, 2002). Only primary outcome studies (from 1988 to 2005) were included in the meta-analysis (Gingerich & Peterson, 2012) and in total 22 studies involving 1,349 participants found a .26 for internalizing behaviours and .26 for family and relationship outcomes and a mean effect size of .11 for externalizing behaviour (hyperactivity, conduct problems, aggression, family problems) outcomes. Only the effect size for internalizing behaviour (depression, anxiety, self-concept and self-esteem) problems reached statistical significance, indicating overall treatment effects for the SFBT group were different from the control group (Kim, 2008). It was concluded that the review offered a comprehensive report on the effectiveness of the approach, but further research needed to be conducted with larger sample sizes because only 12 of the studies had sample sizes greater than 25 per group; and furthermore attention needs to be paid to research design because all but 1 study had at least 3 of the core SFBT intervention components and only 8 of the studies used a treatment manual or protocol (Kim, 2008), highlighting significant inconsistencies. As with all meta analyses, Kim (2008) had to exclude studies (n = 13) because of insufficient information to compute

effect sizes, even though these studies many have been well designed and produced useful information in evaluating SFBT effectiveness. Kim (2008) argued that the results should be looked upon with caution because of the limited number of studies available for inclusion in the meta-analysis, thus affecting the ability to generalise the findings. Another limitation was related to the quality of the studies where dissertations were also included, a frequent criticism often raised in the use of meta-analyses (Kim, 2008).

1.2.8 SUMMARY

This review has looked at the history of trauma and how it evolved with a clear emphasis on the diagnosis and treatment of PTSD; the significance of individual differences in recovery from trauma, leading to implications for the development of post-traumatic growth; the difference between approaches to treat trauma, and the development of SFBT; recognition of how SFBT can help people who have experienced trauma, whilst taking into consideration the implications of this approach should it be included in the field of trauma therapy. The rationale follows emphasising the need for the present study.

1.2.9 Rationale for the research

The research field is dominated by studies looking at how people cope with traumatic experiences (Linley & Joseph, 2004) and researchers also recognise they need to account for the facilitation of growth through therapy (Linley & Joseph, 2004). It is well established that a traumatic event can act as a catalyst for personal growth and positive change (Joseph & Linley, 2006). SFBT is supportive of this because it asserts that change is inevitable, and that

clients attend therapy because they want to change (de Shazer, 1984). SFBT can be applied to a wide variety of client issues, for example: career counselling (Burwell & Chen, 2006); sexual abuse (Dolan, 1991); and eating disorders, addiction, anxiety and perfectionism (Jeffrey, Guterman & Shatz, 2012). Furthermore, SFBT can be helpful during admission to a psychiatric hospital, which is considered to be a life event that evokes a huge amount of stress in those involved (Kok & Leskela, 1996). In a residential treatment setting, which is where SFBT can be fully integrated (Durrant, 1993) and specifically in a psychiatric hospital, where diagnoses can help to conceptualise problems through language familiar to the system, it is important to bear in mind that a psychiatric diagnosis can still create a variety of possible solutions (Kok & Leskela, 1996). When part of the treatment plan for the individual is compliance with treatment, SFBT can be beneficial because it works from the premise that compliant behaviour could be one of the many solutions (Kok & Leskela, 1996). Despite the evidence to support the effectiveness of the approach in the contexts mentioned, there is a lack of research supporting the potential usefulness of its application to experiences of trauma further justifying the need for this present study.

SFBT is different to problem-focused approaches. It is argued that clients can change without having to dissect their problems, they are encouraged to refocus their energy on achieving the life they want rather than reflecting on why they have the life they do (de Shazer et al., 1986). The facilitation of growth through therapy (Linley & Joseph, 2004) is part of the positive psychology movement, which is seen as providing a balance to conventional psychology. To date most of the research has been overly concerned with the negative aspects of the experiences of individuals and how these experiences might be removed (Linley & Joseph, 2004). Much of the research on the facilitation of growth is limited, even though it is recognised that there are three separate dimensions of growth which have been summarised

by Joseph and Linley (2004) from the research literature: relationships are enhanced in some way because people learn to value the ones that are closest to them; people change their views of themselves, where they might have a greater sense of resiliency; and there are reports of changes in life philosophy where people might find a new appreciation for life. However, because there is little psychometric evidence on what might constitute growth (Linley & Joseph, 2004); at present it is unclear what needs to be done therapeutically to facilitate this. Linley and Joseph (2005) argued that it is important to conduct further research with the intention of discovering ways to promote growth instead of looking at the alleviation of distress. Taking this recommendation into account inspired the focus of this research.

1.3 METHODOLOGY

1.3.1 Introduction

The purpose of this chapter is to explain the methodology adopted for exploring the experiences of solution-focused practitioners in the facilitation of post-traumatic growth. The chapter will outline the rationale for the research; the purpose of qualitative research and why a qualitative approach was suitable for this study; the method used to carry out the study, including design, participants, procedure, data analysis, trustworthiness and ethical issues.

1.3.2 Purpose of qualitative research

A qualitative approach was chosen for this study because it is compatible with the social constructionist philosophy that underpins SFBT. The social constructionist approach to research is concerned with the exploration of human experience by identifying the different ways reality is constructed; where it is argued that there is no fixed reality needing to be understood objectively by the individual (McLeod, 1994; 2001). Therefore, it is a requirement of the researcher to construct or deconstruct the verbal accounts of reality which are offered by participants (McLeod, 1994; 2001) and the researcher is most interested in trying to discover meaningful knowledge, rather than forming a hypothesis to establish what the truth is universally (McLeod, 1994; 2001), which is the purpose of quantitative methods that are designed to measure variables or test relationships and would have been inappropriate for this research.

As the aim of this study was to look in depth at the practitioners' experiences of facilitating post traumatic growth and how they made sense of their experiences, the qualitative method of Interpretative Phenomenological Analysis (IPA) was deemed appropriate as the main principles of IPA are based on the assumption that people are "self-interpreting beings"

(Taylor, 1985); "sense-making" being central to human experience and interaction. Smith et al., (2009) offered some guidance on the process of conducting IPA outlined in a series of guided steps, (used for this study). However, Giorgi (2000) argued that the process of analysis done through an attempt at trying to work to a set of prescribed stages of phenomenological research undermined the true nature of what it was trying to achieve. In defense of the process of analysis offered by Smith et al., (2009) it appears they advocated a systematic process, rather than a prescriptive one, helping the researcher to work through the data in a methodical manner.

In conducting IPA research Larkin, Watts and Clifton (2006) argued that the researcher has to in effect keep their data with two specific aims in mind. *Firstly*, the researcher needs to try and understand the world as the participant sees it (Smith, 1996), and in phenomenology we are concerned with how things appear to us in experience and, in the case of this study, how an individual perceives and talks about the phenomenon of post-traumatic growth. This is very much in line with the philosophy of SFBT where definitions and language used by the participants are fundamental aspects of phenomenology and part of the underlying philosophy of SFBT; and where the practitioner is not the expert, having no pre-existing conceptual or scientific criteria, and making no attempt to produce an objective statement about the experience of trauma. These underpinnings are strengths of both IPA and SFBT. *Secondly*, interpretation is double hermeneutic where the process of accessing the experiences shared by the participants' can become intertwined with the conceptions of the researcher, however these are all necessary parts of the process because participants are making sense of their world and the researcher is trying to make sense of the participants trying to make sense of their world (Smith & Osborn, 2003). This level of interpretation makes the approach different to grounded theory because in that approach the process is geared towards addressing a research question that the researcher might have had in mind (Larkin et al.,

2006). IPA is inductive, rejecting a hypothesis in favour of open ended questions. There are some common misconceptions about IPA in that it is considered to be an approach that is perhaps more simplistic than its relatives because of an overuse of the phrase, 'insider's perspective' (Conrad, 1987), where the researcher aims to see the experiences through the participants' eyes by taking an active role in the research process.

1.3.3 Alternative Methodologies

During the developmental part of this study other qualitative approaches were considered, such as grounded theory, thematic analysis and discourse analysis. The aim of grounded theory is 'to generate or discover a theory' (Glaser & Strauss, 1967) and is defined as the discovery of a theory from data that is systematically obtained from social research (Glaser & Strauss, 1967); it was not the intention of this study to discover a theory because the researcher had no preconceived ideas about what she would gain from the participant's experiences. The researcher's standpoint on this led her to IPA because of the focus on ideography, rather than trying to offer a wider conceptual explanation (Smith et al., 2009). IPA also takes a different perspective to grounded theory when it comes to sample size, where typically grounded theory tends to use larger sample sizes in order to validate the theories underpinning it (Barbour, 2007). Some may argue that having a smaller sample size can limit the findings obtained from this type of study; however this is something that is strongly argued against by Smith et al., (2009) who claim that having a smaller number of participants can allow for a richer depth of analysis.

Discourse analysis takes the view that language is structured according to different patterns that people's utterances follow when they are involved in different domains of social life, the term 'discourse analysis' is therefore a process of analysing these patterns (Jorgensen & Phillips, 2002), but for the purpose of this study it was not necessary to 'get behind' the

discourse to find out what people really mean when they say certain things or uncover the reality behind the discourse (Jorgensen & Phillips, 2002); in contrast IPA is very much about trying to interpret how participants are making sense of their experiences in that moment. Furthermore, the analyst in discourse analysis is often part of the culture and as a result might share many of the taken-for-granted understandings that are expressed by the participants (Jorgensen & Phillips, 2002); in IPA the researcher can be objective by not allowing assumptions to influence the process of analysis.

Furthermore, thematic analysis was considered which as defined by Braun and Clarke (2006) as 'a method of identifying, analysing and reporting patterns within data' (p.79). However, the researcher did not want to give a numerical representation of data for themes uncovered because this would not have captured the essence of the participants experiences overall, and the researcher wanted to avoid being limited to a few themes representing the textual data, hence why in IPA the number of themes that emerge are solely dependent on what the participants' bring (Braun & Clarke, 2006)

1.4 METHOD

1.4.1 Approach

An Interpretative Phenomenological Analysis (IPA) approach was considered appropriate because of its focus on the lived experience of individuals, enabling the researcher to try to make sense of the personal and subjective experiences of the participants (Smith, 2011). Semi-structured interviews were used in order to obtain data from the participants enabling the researcher to become immersed in the process and to 'experience close' rather than 'experience far' (Smith, 2011), due to the fact that phenomenology is part of a movement in philosophy where there is concern for the 'lived experiences' of people, thus highlighting the importance of examining experience in its own terms (Smith, 2011).

1.4.2 Participants

Six participants agreed to take part in the study meeting the following inclusion criteria: they all worked at an SFBT centre known to the researcher, which can frame responses given to questions asked because of the influence of operational factors. However, this centre was chosen for recruitment because it enabled the researcher to verify that the practice was within the remit for the inclusion criteria, and allowed for verification of the credentials of those within the organisation. SFBT was the only approach offered to clients; SFBT was the main approach used; they all had experience of working with clients who had experienced psychological trauma through various incidents, such as rape and violence. Participants had also trained in one of the other main therapeutic approaches such as Humanistic/Person-Centred, Psychodynamic and/or Cognitive Behavioural Therapy; and had studied SFBT since their initial training. Homogenous elements were highlighted in a table (removed to protect identity of participants) in addition to other participant characteristics, where their demographic information is also included.

1.4.3 Procedure

This study was approved by the Ethics Committee of the University of Wolverhampton, School of Applied Sciences. Please refer to appendix 1 for a copy of the ethical approval letter.

An information letter (appendix 2) was sent to two organisations; both offering SFBT to clients. In this letter the organisations were asked for help by referring any potential participants for the study trained in SFBT. It was explained that the experiences' of the practitioners using this approach would increase understanding of how and why it is effective with clients who have experienced trauma; and as the study may be published; it could benefit those who are using this approach in their practice. Once the participants had been identified as a result of the first letter they were then sent a participant information letter (appendix 3) where the researcher introduced herself and stated what her intentions were for the research asking for participants to pass on their expressions of interest to her. It was also explained that near to completion of the study a summary of the main findings could be made available to participants and facilitating organisations.

An informed consent form (appendix 4) was sent by the researcher to the participants via email one week prior to the interview taking place along with a participant information form (appendix 5). In preparation for the interviews, the following materials were all necessary and were issued again in cases where the participant had forgotten to bring them to the interview: consent form (appendix 4); participant information sheet (appendix 5) interview schedule (appendix 8); recorder (Sony IC Recorder); pen and paper; and a timer.

All interviews were conducted face to face in different settings: some in the premises of the organisation and some in the participants' homes. The researcher informed a family member where she was going prior to the interview and asked them to call her mobile if they had not heard from her by a specified time.

A pilot interview was conducted to see if the questions were suitable in providing information related to the research question with one of the participants. The pilot went well and only minor adjustments were needed where some of the questions were refined before the remainder of the sample was interviewed. Appropriate changes regarding the wording and structure of the interview were incorporated into a final version (appendix 8). The pilot data was included within the analysis, because the content was consistent with the remainder of the interviews and relevant to the research question.

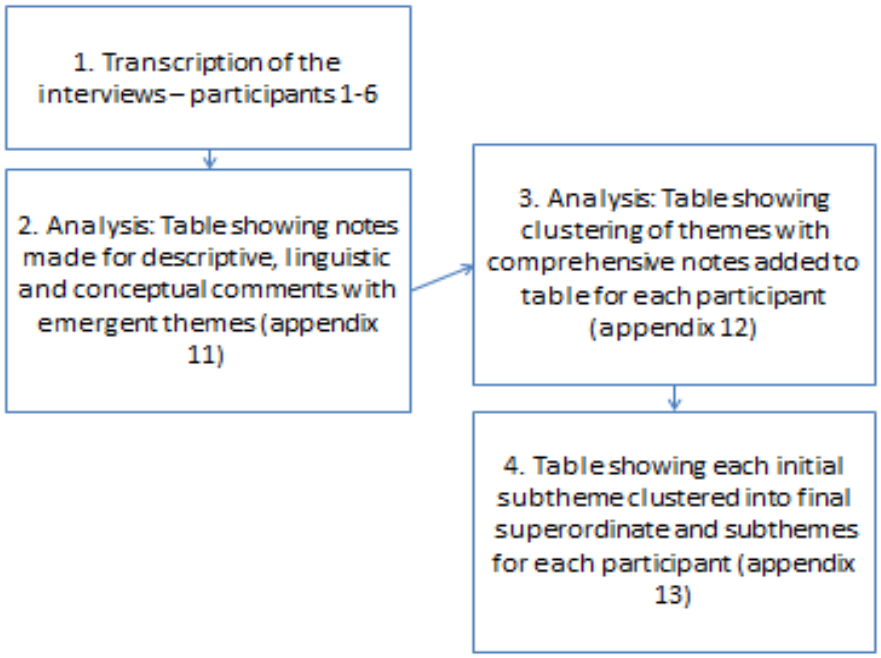
At the start of the interview, the researcher asked the participants to sign the consent form to say they agreed to everything that had been asked of them. The consent form outlined the fact that participation was voluntary; that participants were free to withdraw from the study prior to the interview taking place and even during the interview, after this point it would be difficult to extract the individual information; that the information obtained would be stored in a confidential place; and that their identity would be anonymised with the use of pseudonyms throughout the report. Furthermore, it was also brought to their attention that the researcher may want to publish the study in the future. The interviews were recorded with the intention of using them for the purpose of the study and that any questionable practice may be shared and taken further if disclosed. Participants were then asked to complete the demographic data sheet (appendix 6) and were given the opportunity to ask questions before the interview commenced.

The interview schedule was followed (appendix 8) and prompts were used where necessary if the participant became confused. Additional questions were also asked to enhance understanding in relation to points the participants made. The questions (appendix 8) used for the semi structured interviews were open ended. These were constructed in line with the IPA phenomenological principles of inquiry into the participants' experiences and the meaning they attached to that experience. They were developed by linking them to the research question; looking at the existing literature; and from discussions that took place during supervision. To begin the interview the researcher asked questions about the participants' general experience of using SFBT, leading gradually into a more specific line of questioning about their use of the solution focused techniques, their experiences of working with trauma and post-traumatic growth. The open questions enabled the participant to elaborate on their answers, whilst also bringing different material into the interview. Some clarifying questions were also asked to help the researcher to understand the point the participant was trying to make and on occasions this might have resulted in closed questions being asked. However, the researcher tried to stay as close to the interview schedule as possible. On occasions questions were linked with prompts to help the participant to answer the question if they became a little stuck.

Once the interview had ceased and the Dictaphone had been switched off, the participant was given the opportunity to check in with the researcher by sharing their thoughts and feelings about how they had experienced the interview. A debrief form (appendix 7) was issued to the participant and an identification code was allocated to the participant. On the debrief form participants were reminded that if they wanted information about the outcome of this research once it had been completed then a summary of the findings could be prepared for them upon request via the contact details.

1.4.4 Data analysis

The following chart highlights the different stages of the analysis process. Only the clustering process can now be found in appendix 9, the other stages have been removed to protect the identity of the participants:



1.4.5 Transcription process

The audio files were downloaded onto a laptop and password protected. The recording was converted to a switch sound file to make it compatible with the Express Scribe Software Package. This enabled the researcher to play the recording slowly whilst typing using the Word Programme. The completed transcription represented a verbatim report of the interview sessions and any notable non-verbal utterances like laughter and pauses were represented by using bracketed text, as recommended by Smith et al., (2009). The transcript was also line numbered and large margins were used to allow for the researcher to make notes during

analysis. All data pertaining to the interviews was stored on a laptop with the intention of deleting it once the project had been completed.

1.4.6 Reading and re-reading

The first step of the IPA analysis was immersion in the original data, by reading and re-reading the first written transcript. During this process the researcher was also listening to the audio recording because it helped her to imagine the voice of the participant and get a sense of the interview as it was at the time. Whilst the researcher's interpretation is central in IPA research, during the interviews the researcher followed the recommendations of Smith et al., (2009) by bracketing off powerful reflections of the interview experience focusing primarily on the participants' accounts leaving the interpretation until the analysis stage. Important reflections were noted in a journal to prevent her from allowing her assumptions to influence her ability to remain neutral.

1.4.7 Initial noting

The above process ensures a growing familiarity with the transcript. The researcher attempted to keep an open mind so as to enable her to identify and understand how a participant talks and thinks about an issue. Notes were made on each of the transcripts (example in confidential attachment) as she was reading through them and further exploratory notes and comments were added with subsequent readings (Smith et al., 2009). Constant comparison on the detailed notes added in the left hand margin helped the researcher to pay attention to the subjective experiences of the participants in line with the recommendations given by Smith et al., (2009) which involved: firstly, notes made on the descriptive comments focusing on the content of what the participant was saying; secondly, notes were made on the linguistic comments which explored the use of language through tone, pauses, utterances and laughter;

and thirdly, notes were made on the conceptual comments focusing more on the conceptual level of understanding.

1.4.8 Individual case analysis

In line with Smith et al., (2009) this stage of the analysis involved the identification of emergent themes where connections could be mapped and patterns noted across notes was involved in this stage. In the left hand side margin notes were made to remain close to the original data whilst identifying meaningful parts of the transcript which helped to illustrate themes that were starting to emerge. A note was made of these themes and they were consequently clustered and checked against the original transcript to ensure that accurate reflection was taking place as highlighted by Smith and Osborn (2003). From this all of the themes were worked through on a piece of paper and links were made where the researcher could put them into an analytical/theoretical order. Smith et al., (2009) suggested that sub themes are then clustered together and overarching themes are then identified to help to explain the sub themes. Tables of emergent themes (in confidential attachment) were created with relevant quotes used to reference the location of it within the transcript.

1.4.9 Cross case analysis

The process outlined for the individual case analysis was then repeated for all of the other transcripts as outlined by Smith et al., (2009). In order to remain true to the idiographic nature of IPA, it was essential to bracket any assumptions or ideas left with the researcher from previous transcripts. Once the process had been completed the researcher returned to the original transcripts to look for patterns and potential connections across them, paying attention to differences and similarities. The themes are outlined in a table (appendix 9) showing the clustering process that took place where themes were identified reflecting the experiences of the participants and subsequently drew on the interpretative nature of IPA.

1.4.9.1 Reliability, validity and ensuring trustworthiness

Validity, when considering empirical research, is rooted in the positivist tradition, where the terminology tends to be associated with empirical conceptions, for example, evidence and truth (Winter, 2000); an approach very different to the social constructionist position of this study. In a qualitative study, reliability can be understood as aiding our understanding of a phenomena, that could otherwise prove confusing or enigmatic (Eisner, 1991); and the examination of trustworthiness is integral to ensuring the reliability of a qualitative research project (Golafshani, 2003). Furthermore, Lincoln and Guba (1985) argued that sustaining trustworthiness depends on the issues described quantitatively as validity and reliability. Strategies have therefore been proposed to ensure trustworthiness in qualitative research projects (Shenton, 2004). It was argued by Shenton that the trustworthiness of qualitative research is something that is often questioned by positivists because validity and reliability cannot be addressed in the same way as more naturalistic research (Shenton, 2004). The following provisions can be made to promote confidence that the phenomenon is being accurately researched.

Credibility

- *The adoption of research methods well established'* – the specific procedures employed, for example the questions utilised in the semi structured interviews were closely linked to the research material and the method of data analysis – IPA is well established as a means of looking at phenomenology; where subjective experiences were studied in relation to the research question.
- *'The development of an early familiarity with the culture of participating organisation'* – the researcher was familiar with the participating organisation, however she was not so immersed in the culture that her professional judgement was compromised; she could remain detached from the organisation having never worked there.

- *'Tactics to ensure honesty*' – each participant was given the opportunity to refuse to participate in the study and those who took part were very keen to share their experiences. Furthermore, all participants were aware that the researcher was independent to the organisation and could talk about their experiences without fear of losing credibility.

- *'Peer scrutiny of the research project'* – the researcher made the most of opportunities to have the research scrutinised by peers and her supervisors, so that she could get feedback – this was particularly apparent when writing the results section because closeness to the project could have inhibited her ability to view the findings objectively. Furthermore, questions posed by the supervisors enabled her to develop a greater explanation of the methods employed to conduct the research, strengthening the overall design of the project.

- *'The researchers reflective commentary'* - a research journal was used throughout, where it was important to capture initial impressions, patterns emerging between themes and general thoughts on the effectiveness of the interviews in making sense of the participants' experiences.

- *'Background, qualifications and experiences of the researcher'* – the credibility of the researcher was supported by ethical approval gained from Wolverhampton University and she was continually monitored by her supervisors during the research process – this information was included in the participant information sheet.

- *'Member checks*' – informal conversations took place with the participants at the end of the interviews "on the spot" where accuracy of information obtained was checked and participants were given the opportunity to ask questions about the interview process. Supervisors also conducted member checking; one of the supervisors met the inclusion criteria because they are a Solution Focused Practitioner and was able to check themes, check analysis and discuss transcripts to see if similar themes emerged.

Transferability

- Shenton (2004) recommended that the background to the study should be explored because it positions the research in a wider context allowing for questions to be asked about the phenomenon under investigation, which in this study was the facilitation of post traumatic growth through SFBT. Other studies were discussed in the literature review in order for comparisons to be made.

Dependability

- Shenton (2004) discussed the standpoint of a positivist researcher who employs techniques to try and demonstrate that if the work was repeated in the same context, with the same methods and with the same participants' then similar results would be obtained. The processes within the study were outlined in detail, for example: the research design (planning and implementation), data gathering, and reflective appraisal of the process of inquiry, with the intention of enabling a future researcher to repeat the study, but not necessarily to gain the same results (Shenton, 2004).

Confirmability

- Shenton (2004) argued for the use of processes that must be followed to ensure that the findings obtained are a reflection of the experiences of the participants, rather than giving an indication of the preferences of the researcher. Decisions made about favouring IPA over other methods of analysis were discussed openly in the research project and weaknesses in the data analysis processes were admitted. The reflective commentary that was apparent in the research diary enabled the researcher to explore decisions made at the time. Furthermore, an audit trail (included in the appendices) allows for the research to be examined step by step and a diagram has been included in the method section to give a visual representation of the process followed to analyse transcripts.

1.4.9.2 Ethical issues

1.4.9.3 Informed consent

The initial information sheet was sent to the organisation, referring interested participants to the researcher. Once potential participants had been identified as wanting to be involved with the research an information form (appendix 5) was sent to them via email requesting further information. Participants' details were protected in the email account accessed by password only. Potential participants were informed about the purpose of the research and the point at which they could withdraw if they no longer wanted to take part in the research. The consent form (appendix 4) was given to participants in person, so that they could absorb the information and ask questions – signed consent was given in front of the researcher. The consent form highlighted the fact that participation was voluntary and that the interview would take no longer than one hour.

1.4.9.4 Confidentiality

When participants were issued with the consent form (appendix 4) it was important to make them aware that: all of the information obtained would be treated with sensitivity and discretion: the interview would be conducted confidentially; participants would be given pseudonyms to protect their identity and any identifiable information would be excluded. Furthermore all information collected was to be stored in accordance with The Data Protection Act (1998). The information will be archived at the University of Wolverhampton for a period of five years or for the period of time that is required.

1.4.9.5 Safeguarding

Participants were informed at the outset that confidentiality would be breached in the event they disclosed negligence, unethical practice, or harm to others. This is in accordance with the British Psychological Society guidelines (BPS, 2009; BACP, 2010; HCPC, 2012). Consideration was given to ensure the wellbeing of participants if something was disclosed during the interview that may have had the potential to cause them distress, and that this would be addressed by advising them to take it to supervision and/or personal therapy. The researcher also ensured that her own safety was safeguarded, when conducting interviews at different venues, by informing her family of her whereabouts and asked that they contact her if she had not checked in with them by a specified time.

1.5 RESULTS

1.5.1 Introduction

This chapter presents the findings from the Interpretative Phenomenological Analysis of six semi structured interviews conducted with solution focused practitioners who have experienced facilitating post traumatic growth during brief therapy. Reflections on the participants are not included here to protect identity of participants. The six interviews found the emergence of four superordinate themes displayed in table 1.2:

Table 1.2. Table showing superordinate themes and a quote illustrating these themes

Superordinate themes	Example quote
Who am I? - becoming a solution focused practitioner	*"I just felt like I was coming home, it just, well everything suddenly made sense more, so it all came together and produced a more concrete version of what I already thought would be"*
A problem world where trauma is present	*"So she came very traumatised by that and she well her whole world, really she is right at the centre of her problem world, she couldn't think of a way out .... the clients comes with a problem and that just becomes their whole world"*
A positive cocoon where growth can occur	*"Really enables them to see life really is happening anyway beyond, or away from the problem, they are doing already, they are doing very good"*
The longevity of the approach – a small fish in a big pond	*"you only have to look around our little neck of the woods, you come to our conferences and... you realise it's not particularly fashionable"*

Exploration of these superordinate themes and their associated sub themes (table 1.3) will form the basis of this chapter and the frequency of themes (table 1.4) was linked to verbatim extracts illustrating each subtheme.

Utterances such as ‘hmm’ and ‘ahh’ have been removed. Dotted lines will indicate that there was material before and after the extract taken from the bulk of text demonstrated through the use of squared brackets.

Table 1.3. Four major themes and their associated subthemes in columns

Who am I? – becoming solution focused	**A problem world where trauma is present**	**A positive cocoon where growth can occur**	**The longevity of the approach – a small fish in a big pond**
Self-discovery – what was missing?	Making sense of it through experience – it is in the eye of the beholder	A different lens – a change in perception	Spreading the word
The evolvement of the therapist	Use of problem language and labels to categorise	The co-construction of a new reality through language – connected conversations	Striving for acceptance
Values and beliefs – the underpinning philosophy	The position of the client - agenda	Building resilience through positivity and optimism – the survival instinct	Moving with the times – a growing need for brief therapy
Knowing it works- Application of the approach on a personal level	The trauma identity – part of the system	How much do they want to move on? Maintenance of growth	The potential pitfalls of the approach

Table 1.4. The frequency of subthemes for each participant.

Superordinate	Subtheme	PP1 Lucy	PP 2 John	PP3 Ben	PP4 Matt	PP5 Chris	PP6 Victoria
Who am I?	Self-discovery – what was missing?	✓	✓	✓	✓	✓	✓
	The evolvement of the therapist	✓	✓	✓	✓	✓	✓
	Values and beliefs – the underpinning philosophy	✓	✓	✓	✓	✓	✓
	Knowing it works- Application of the approach on a personal level	✓	✓	✓	✓	✓	✓
A problem world where trauma is present	Making sense of it through experience – it is in the eye of the beholder	✓	✓	✓	✓	✓	✓
	Use of problem language and labels to categorise	✓		✓	✓	✓	✓
	The position of the client – agenda	✓	✓	✓	✓		✓
	The trauma identity – part of the system	✓	✓	✓	✓	✓	
A positive cocoon where growth can occur	A different lens – a change in perception	✓	✓		✓	✓	✓
	The co-construction of a new reality through language – connected conversations	✓	✓	✓	✓	✓	✓
	Building resilience through positivity and optimism – the survival instinct	✓	✓	✓	✓	✓	✓
	How much do they want to move on? Maintenance of growth	✓	✓	✓	✓	✓	✓
The longevity of the approach – a small fish in a big pond	Spreading the word	✓		✓	✓	✓	
	Striving for acceptance		✓	✓	✓	✓	
	Moving with the times – a growing need for brief therapy	✓	✓		✓		✓
	The potential pitfalls of the approach	✓	✓	✓	✓	✓	✓

1.5.2 NARRATIVE SYNTHESIS OF FINDINGS

1.5.3 WHO AM I ? – BECOMING SOLUTION FOCUSED

The superordinate theme 'who am I' represents the academic and intellectual nature of the participants descriptions of their experiences. Participants describe having values and beliefs that determine how they facilitate SFBT. This theme is explored in relation to four subthemes which are:

- Self –discovery – what was missing?
- The evolvement of the therapist
- Values and beliefs – the underpinning philosophy
- Knowing it works – application of the approach on a personal level

A process of self-discovery – what was missing?

This subtheme reflects the experiences of the five practitioners, where three of them started with a foundation in psychology and two of them with a foundation in counselling and psychotherapy. There was a sense that there was something missing from their educational learning experiences because it left them wanting more, this was aptly put by Lucy who stated, "we wanted to know more" (Lucy, P1/31-32).

Participants expressed frustration as their appetite for learning had not been satisfied by the training received in previous educational settings. A quote that illustrates this point comes from Lucy, who commented,

> "Yeah, see what I mean all we were doing was applying understanding, so applying theory or yeah, applying theory or understanding of yeah, that's it and so I didn't really enjoy that part of it, I wanted something more, that made me think or made me (inaudible) something, what actually I wanted

> was some new insight, an area of knowing or talking about the human condition really" (Lucy, P2/45-50)

Studying Psychology for example was limiting, as participants coming from this background were restricted by the idea that they had to conform to what was expected of them in the application of the approach, this process of learning was also evident in their personal lives, as Matt identified he became aware of a distorted thinking style,

> "[...] this always happens to me, rather than actually when you look close there are exceptions to that and it doesn't always happen [...] it changed my thought processes" (Matt, P2/55-57)

There was a sense that participants could work with SFBT naturally because it almost felt like second nature to them requiring little effort to try and get it right. This point was illustrated by Victoria who commented,

> "[...] so I kind of try and apply myself a little bit more and, and (pause) I think I am by nature a sort of, quite a practical solution focused person, I always want to think about okay well what can we do about it" (Victoria, P12/497-499)

Despite this natural way of being that the practitioners talked about, some of them had not realised that it had become an integral part of their working practice. John felt that after learning about psychology he took the knowledge he acquired into his career as a teacher, "Well I wasn't trained as a teacher to work in a solution focused way, I just did [...] (John, 1/22-24) and once he had the opportunity to study SFBT it validated the feelings he had about his previous experiences,

> "I just felt like I was coming home, it just, well everything suddenly made sense more, so it all came together and produced a more concrete version of what I already thought would be, well, I have worked with kids with, challenging kids all through the years I have been a teacher" (John, P1/33-36)

Participants all described a need for knowledge and an aspiration to be a 'good therapist'. John described an underlying aspiration to work in a similar way to one of the greats. "[...] he influenced me greatly in the way I performed as a person and as a teacher from that time on (John, P1/26-27). John almost used this as a way to justify his decision to work in a solution focused way, despite not learning about this on the course he undertook previously. For Chris it was a gradual evolvement and came from a career where he might have been influenced by the medical model, "I trained as a psychiatric nurse" (Chris, P3/152); he built on this by engaging with therapeutic work,

> "I started off like most people do, you don't wake up one morning and say I'm gonna be a […] a solution focused orientation, […] my original orientation would have been more client centred" (Chris, 2/62-65).

He assumes that most practitioners who enter therapy are positioned in the person centred approach, but quite clearly there was something missing from the experiences of the practitioners interviewed for this study because they wanted to learn about SFBT having come from that orientation. Victoria started off with a diploma in person centred counselling and talked about how she integrated her learning with SFBT,

> "I began with a diploma in person centred and I think that is, I mean that's core to most therapies really isn't it, that's the relationship, the empathy,

> the positive unconditional regard, the non-judgemental stance that you take as a therapist and that's still very much the case with solution focused but I suppose for that (pause) it almost relies on you, you, it being enough (Victoria, 2/80-84)

The skills acquired by the practitioners provide a firm basis from which to develop and Matt although acknowledging this learning felt that SFBT enabled him to take a different perspective.

> "I think it gave a different perspective because at the time I was doing Humanistic, person-centred counselling, so it was kind of being led by the client and paraphrasing and using all the basic listening skills" (Matt, P1/23-25)

Interestingly the practitioners did not stay with the person centred approach because they wanted something more, hence why they then pursued SFBT. This realisation might have come through their experience of working with clients, but for some they undertook various courses before SFBT,

> "I was first introduced to it in about 1998/1999 although we used to have conversations about it before when I was a Klenian when (laughs) [...] I was very much into TA and all that, the humanistic sort of malarkey" (Ben, P1/9-13)

> "[...] the psychodynamic approach [...] didn't easily sit, it wasn't that comfortable for me as a person (pause) because you are supposed to be this kind of opaque therapist who kind of, is listening for what's going on beneath the surface" (Victoria, P3/116-119)

It was important for Victoria to feel connected to the approach she was working with and there was reluctance perhaps on her part to then apply psychodynamic therapy to her client work. As with many therapists when they undertake their training they have to experience therapy as a client and having experienced psychodynamic therapy first hand she found this quite a difficult process,

> "I think I also had 50 months of psychodynamic counselling myself as part of my training and I found that quite a difficult, quite a bruising in some regard" (Victoria, 3/126-127)

All of the practitioners went through a process of development because they were conscious of working with clients in a way that fitted their personalities, this is pertinently demonstrated by Matt, "[...]I think one of the key things about solution focused for me is because I could make sense of it myself in my own life, it kind of gave me that confidence to use it with clients" (Matt, P2/62-64), this was also something that was observed in clients because they also went through a process of self-discovery, "[...] recognise that once she had changed the way she thought about the process, it ultimately had an impact on how she was feeling" (Matt, P10-11/437-441). This was something all of those that had experienced SFBT could relate to in some shape or form, because even though they had come from different backgrounds all of them had benefited from the approach.

Building on foundations – evolvement as a solution focused brief therapist

This subtheme relates to the feeling that each practitioner got from finding SFBT. Most practitioners once they had discovered the approach had stayed with it for a long time, and had gradually moved away from psychology, "prior solution focused I was doing my undergraduate degree [...] a normal psychology course [...] after that I was thinking of study

more" (Lucy, P1/29-31). Interestingly all of the male practitioners felt that SFBT made sense to them because before discovering it Chris suggested that, "we all sort of dabbled doing different things [...]" (Chris, P4/134-135); it was almost like a lightbulb moment they had not gained from their training previously.

> "[...] when I have been learning CBT and other approaches I have kind of tried to stick rigidly to the model, whereas in solution focused it allows me to be with the client and listen to what they are saying" (Matt, P6/223-226)

The female practitioners were different in their perceptions. One of them was in training, so did not have the experience necessary to say if and how it had impacted upon her working practice personally and was very much aware of her identity when it came to making decisions about clients suitable for therapy, "as a trainee I don't, I'm not part of that decision making process" (Victoria, P1/22-23. She also reflected on her progress with the working application of the approach feeling at times like it was a little direct in its application, perhaps by comparison to other approaches she was more used to, "felt to me like "oh god" moment you know and I suppose she will never come back [...] was a bridge too far really [...] she came back the next week" (Victoria, P8/347-350). The other female practitioner had only ever used SFBT in her working practice, so could not really compare it to any other methodologies, although she had an awareness of these.

> "but in CBT because it's from a scientific model, it is a scientific way of looking at human behaviour and doing therapy yeah and so therefore they have the values or the belief that there is something out there, there is a problem there for us to explore and tackle, but a solution focused way of

> believing is that the problem is not there (laughs) it is only how we see it, it is relative" (Lucy, 11/472-477)

Lucy is clear about the difference between CBT and SFBT. As with all of the practitioners they rebelled against a scientific way of looking at problems, this was illustrated by Chris aptly summarised this by stating, "[...] it's about the perspective the person has." (Chris, P8/340). Using SFBT helped the practitioners to develop a new perspective and to also increase their self-awareness. Matt was able to think about how he approaches client issues on a personal level and becoming aware of SFBT encouraged him to reach this conclusion,

> "[...] the natural thing certainly for me is, is to kind of think about what's gone wrong, what haven't they got, …rather than what they have, so it's, it's almost like kind of how we socially construct stories and it's, it's easy to look at the half empty rather than half full" (Matt P1/49-50)

It felt that once the practitioners had started to look within themselves and make the personal changes necessary to become better individuals and more accomplished therapists because of their connection to the approach, there was a loyalty to SFBT,

> "Well I've become more and more solution focused and I don't have a tendency to go back into the other methodologies I was trained in because, that's because continually teaching people to do it, well I am continually refreshing myself" (John, P8/312-314)

Over time he has noticed that his way of being on a personal level and in his working practice has been further engrained in SFBT. However, he is also aware of the fact that if someone does not continue to make a conscious effort to apply SFBT they can regress, "I know everyone has a tendency to revert back to problem focused to an extent, the further they are from their training (John, 8/316-317). He has avoided the other methodologies because they

might not fit his personality anymore due to the fact that he has changed/evolved, or it could also be that he enjoys the solution focused way and does not feel the need to revert back to other approaches. This is also something that Ben acknowledges because he felt similar,

> "Now I try, I work very differently and I work in an ethos of solution focused approach rather than just demonstrating the skills you see [...] even now as we speak in this (pause) in this particularly formal setting (inaudible) I would be demonstrating curiosity, hope" (Ben, P2/59-62)

Ben has evidently developed as a practitioner because at the start he was making a conscious effort to try and work in a solution focused way. However, with experience came his ability to be solution focused in his way of being, "my approach has changed all of the time, so the solution focused work that I do now is very different to that I did in 1999" (Ben, P2/53-55). This is something that Matt could also relate to where he felt that he too was naturally solution focused, "I think you have got to really buy into that model and [...] it just seems a little too easy to work [*with*]" (Matt, P12/520-521). For Matt there is a sense that he finds the approach easier in comparison to other approaches because it has become an integral part of who he is. His use of language indicates that he has invested time and effort into the model because he "buys" into it, which is something all of the practitioners have been prepared to do. He also talked about the influence of supervision and his ever increasing awareness where he admitted that his understanding of trauma was validated, "my supervisor has said it sounds like that has been a traumatising experience" (Matt, P8/320-321) and from this awareness it enabled him to have a focus for therapy, "[..]the key thing is it sharpened up my focus for the sessions, so it wasn't just about going round in circles" (Matt, P1/38-41). Also when thinking about influences on working practice, Chris identified that the setting in which a practitioner works can also lead to advancement, "I tend to integrate more [...]" (Chris, P1/23-28 and "I

am expected to be more fluid shall we say" (Chris, P1/35-36). Although there were no concerns expressed about the influence of the context of working practice, practitioners although loyal to SFBT were expected to adapt to covert external expectations.

Values and beliefs – the underpinning philosophy

In this sub theme all of the practitioners recognised the importance of their own values and beliefs which helped them to initially find SFBT and to work in a way that complemented SFBT and their innermost values and beliefs. In relation to the previous subtheme this acknowledges the evolvement of the practitioner on a deeper level where they almost use their beliefs and values as a catalyst for client change and growth because they had also gone through a process of growth having experienced it on a personal level.

> "I think you have to have the belief that, that people can change and can change themselves, that leopards can change their spots really" (Victoria, 12/509-511)

Victoria felt that having that belief in the client, when perhaps no one else did really helped the client to move forwards. She recognises that people can change and has perhaps experienced this with the client work she has undertaken. She also does not take responsibility for the changes that occur and almost suggests that it is the responsibility of the client and what they are willing to put into therapy. This was aptly put by Ben who stated, "[...] I think some people work better with it" (Ben, 4/155-157).

All of the practitioners felt passionate about the belief system they were able to work from to help the clients, even if the client was resistant to change, "[...] it's usually [...] where they're positioned within their own world" (Ben, P4/159-162). In situations like this Lucy felt that

the belief system the solution focused practitioners have can help to shape sessions, she illustrated this by saying,

> "Not bring ourselves really hmm what we believe, or what, our value system as solution focused practitioner drive the session" (Lucy, P6/222-223)

Lucy was keen to highlight that it was not the practitioner per se that evoked change, but it was what they represented as people and their value system that served as a foundation on which to build upon. There was a sense that she was determined to try and bring about change for the client because she used the word "drive" as if to suggest that she would perhaps at times steer the client in the right direction.

The general consensus from all of the practitioners was that they had a sense of hope that things could be different and through this positivity the clients responded well to the belief they had in them as individuals. This was illustrated by Chris who stated, "[...] it's about looking at your life as it is and rather than actually wanting, desperately searching for something more" (Chris, P2-3/88-90). The therapeutic space therefore becomes a nurturing safe haven in which the client can grow and become more aware of the aspects of their lives to be thankful for and in which they were functioning.

Aside from the impact of the practitioners' belief system on the clients it also became apparent that the practitioners were reflecting on how their beliefs and values influenced them personally. Chris commented on this, "[...]those philosophies I am working with now, you know have enabled me to actually deal with my own, my own traumas [...] I don't need to work with that, or think about that anymore, so I just do the work I do" (Chris, P15/638-643). For John it made him more aware of his own limitations and how far he was prepared to test that,

> "Well its helped me get to my age and still remain fit and healthy, although there are problems, I have created problems by working hard at my fitness, its allowed me to be a lot more decisive and resilient in my own life and more useful to the people around me" (John, 12/495-498)

Being solution focused has helped John to become more decisive and resilient in life, which suggests that this was something that might have been lacking previously. The underpinning philosophy of the approach was embraced by the practitioners because they showed some awareness of its existence.

> "Ah okay, what it means to me, is about really reality, reality is what we, what we experience [...] how we see the world [...], reality is nothing there out there, it is nothing out there that is fixed for us to explore or fathom out, reality is what we see, so through, [...]how we see is influenced by the language that we carry around in, really since we are born and that we acquire" (Lucy, P2/78-83)

Lucy has a clear understanding of social constructionism and touches upon the importance of the philosophical underpinnings of SFBT. This was also illustrated by Matt, "[...] I guess the one thing that I have learned from solution focussed is about social constructionism, how we construct our realities through stories that we tell and the way we see things" (Matt, P5/201-204). Furthermore, he also emphasised how clients get stuck and lose sight of their qualities, "[...] I feel really stuck [...] I guess changing the way that construction of how they made sense of that trauma" (Matt, P12/485-487). It seemed important to help clients to believe in the opportunities for a new construction of realty and to value their experiences thus far.

By taking a solution focused approach to clients there was recognition of the positives to be taken from seeing them as "lovely people", "[...] just beginning to discover that everybody has a lovely side to them" (John, P7281-282). The significance of the solution focused

approach and how it can help a client is captured by Victoria who stated, "so I feel it is an honest approach about what a therapist can do really" (Victoria, P12/486) this suggests that the approach should be taken on face value because it does not offer recommendations about specific ways of working with clients.

Knowing it works on a personal level

Moving on from the previous subtheme this emerged as a result of the practitioners going through a process similar to the clients because they had all grown in different ways. This is something that is particularly highlighted in Ben's account where he feels that he has taken on the solution focused philosophy as the only way of being for him,

> "I live the…definitely live a constructionist life, it's not easy I, I even think about the future, myself in terms of well I can make different choices, I can make different changed, the language I use determines me by the word I…I am defined by language per se" (Ben P16/674-678)

Ben has chosen to live life according to principles of social constructionism and recognises how his use of language has a powerful influence over how he perceives himself in relation to others and this is something he encourages his clients to be aware of perhaps. He can also identify with how difficult it can be to take on this way of being, where one would assume that the clients he works with are invited to share in this process. This was reflected in Chris's decision to work with SFBT because for him it was validation of progress, "We are moving forward, we are developing and responding and investing in new information about ourselves." (Chris, P11/447-449). Through experiences practitioners were confident about the fact that the approach worked and were then more likely to apply it to their client work. This was summarised by Matt who stated,

> "One of the key things about solution focused for me is because I could make sense of it myself in my own life; it kind of gave me that confidence to use it with clients" (Matt, P2/62-64)

Matt gained a sense of confidence from his application of the approach because he experienced first-hand how powerful it could be. This is also something that Victoria could relate to because she commented,

> "Yes, yeah absolutely, yeah, yeah I do it at home sometimes as well you know when it, when it, I feel awful when on a scale of naught to ten how awful you know (laughs) we might laugh about it, but it kind of well it actually gets it into a bit of perspective" (Victoria, P12/492-495)

On a practical level it seems that the scaling intervention can help the practitioners to put things into perspective not only for themselves, but also for the clients. On a personal level it also enabled Lucy to notice how she had developed as a result because her perception had changed, "I think now I have changed my way of viewing it because, in my way, well I understand it is only me, to others his way might be ok" (Lucy, 10/417-418). Lucy perhaps recognised that at times she could be quite ego centric in her views. She is now more accepting of others and can see that other people may have a very different opinion to her. She also recognised that the approach had changed an aspect of her personality, "I have become [...] a much more tolerant person" (Lucy, P9/410-413). Engaging with the approach evoked a process of self-reflection where practitioners' identified areas that needed development, attempting to implement changes that would make their working practice more effectual and generally nicer people on a whole. John shared a very personal example of this when he stated,

> "My youngest daughter was telling me, yesterday we were having a chat, she is 19 now and she was saying I think it's being around you that allows me not to get upset with people and be nasty and horrible when they say horrible things, you know when people say horrible things I just say well yeah well what's that all about then and they, well she just laughs it off and lets it go, she doesn't take it personally, yet when she was little, when she was in junior school she used to get very upset about comments and would take things very personally, so she has grown through that, so I think it rubs off on the people around you" (John, P12/495-498).

John has learned not to take things for granted, as with all of the practitioners they were open to the process of learning. This is further supported by Chris, who stated, "it's about being who I am and being honest with myself, with the people that I now and work with" (Chris, P3/92-93) and [...]look at life differently through the vehicle of SFBT, but to also look inward" (Chris, P3/98-100). Perhaps part of the practitioners' personal journey was that they were striving towards self-actualisation. Despite the somewhat limiting settings in which they might work they are still able to be true to themselves, even when specific contexts might dictate what approach is taken with clients, "I am a purist, but I have to integrate, my underlying belief system is very much around [states religious alignment], I am here as a counsellor" (Chris, P2/74-85). Chris in his work setting has to integrate different therapeutic approaches and is unable to work in a purist way. What is noticeable is that the practitioners felt comfortable to share their personal experiences and views with the interviewer, so that she could at least recognise they were being true to themselves despite the false nature of the semi-structured interview process, which is a reflection of how they might function in their restrictive work environments.

1.5.4 A PROBLEM WORLD WHERE TRAUMA EXISTS

The superordinate theme ‘a problem world where trauma exists’ represents the acknowledgement of a trauma world full of problems and the reluctance of the solution focused practitioner to get drawn into that world. This theme is explored in relation to four subthemes which are:

- Making sense of it through experience – it is in the eye of the beholder
- Use of problem language and labels to categorise
- The position of the client – agenda
- The trauma identity – part of the system

The main concepts within this superordinate theme emerged from the participants’ experience of working with trauma in a problem world where trauma has become categorised. They understood the notion of trauma; however the participants did not explicitly refer to this with the use of labels unless it was something that was initiated by the client.

Making sense of it through experience

The participants tried to understand what trauma meant to the clients on a personal level, Lucy summed this up by saying, “[...] well a client’s trauma to them is a problem isn’t it” (Lucy, P3/96) and how it might present itself in a solution focused therapy session, which was something that was different for every client. All of the participants were able to give a specific example of a time when they worked with trauma,

> “I had a client, she, she was going through, not divorce, separation, yeah separation, and all the court cases and all about the children, court cases about

her child who was having the child, yeah things like that, she was quite traumatised by the whole experience" (Lucy, P4/165-168)

"I've worked with people who've had physical trauma you know they've lost, they've lost well some people have lost their job and they all describe that as a trauma they will say the trauma you know the trauma I have gone through as a result you know of being told I am losing my job, so I just think it encompasses so, so many things (Chris, P8/334-338)

"I guess the work that I have done with clients who have experienced some traumas there has tended to be more long term and its usually been well what has certainly the examples that I am thinking of at the moment well a lot of it has been childhood based trauma, so something that they have probably experienced early on in life and have, have come to therapy as adults" (Matt, P7/275-280)

"She like tended to the little girl and had to sort of press her hand on her neck wound and [...] and try and keep her going basically until the ambulance arrived, so traumatic, that was a traumatic event I guess (Victoria, P8/312-316)

"So it was these, was these primary diagnoses because we need them, but not all of them, but at the root of the matter was that mom and dad had an affair and she discovered it, there was a whole bunch of stuff with lots of secrets within, well there was all this trauma" (Ben, P11/461-465)

"It can be people who have died, the most horrible things can happen as you can imagine, you know peoples' blood vessels burst and blood on the celling

> and all-round the curtain and they are trying to save someone's life and the registrar has hit hands on their heart pumping it, all these things go on, so it is about experiencing, traumatic things happening and not just on the ward, but in surgery" (John, P11/463-468)

Practitioners tried to link their understanding to theory in an attempt to make sense of what trauma meant for the client, which was a very personal thing.

> "I could come out with loads of fancy you know models and sort of say well actually it's about this and there is regressive trauma and there is this trauma and that and in the past we did all of that in the 80's and 90's when psychology was looking at that, but I am not sure it's like that anymore, well certainly that is just one view isn't it. Trauma is quite a personal thing" (Ben, P5/193-207)

This might suggest that the practitioners were reluctant to make assumptions about what it could mean and that despite all the theories that could inform the participants it became clear that they preferred to make their own minds up about what it was and how they could work with it,

> "What has happened to them has caused this emotional reaction and this immense fear and because of my psychological background and as you know keeping up to date with neurological discoveries it's important for me to actually start helping them to get their feelings back under control" (John, P3/110-118)

John felt that to understand trauma he had almost taken an academic perspective because there was a need to keep up to date with neurological discoveries, this was something that Chris also did because he admitted to doing some reading around the topic,

> "I've not overplayed the idea of [...] I mean I've read quite a few you know papers and books on trauma and how it has, managing the impact, I have a book somewhere, an SFBT based book on managing trauma, so it has been written you know" (Chris, P8/346-351)

Both practitioners were perhaps aligning themselves to the position of the interviewer who as a Trainee Counselling Psychologist is also keen to make sense of these experiences. Interestingly Chis had almost rebelled against the idea of trauma and this was something Ben shared because he felt that trauma was something was dramatic,

> "It's that acuteness, it's about the families in distress, the breaking up because of drugs and stealing cars and poverty and all of that usual stuff that makes good TV" (Ben, P5/188-191)

In some ways Ben was a little disparaging when talking about trauma, he felt that it was something that was in a sense man-made because it may have come as a result of the television programmes people are exposed to, which could have influenced their perception in some way. This was something that all practitioners could relate to because clients perceived their problems as trauma, Lucy aptly summarised this, "all clients are traumatised because they are traumatised by their problems obviously" (Lucy, P9/397-398)

Furthermore, trying to understand trauma was not always easy because the practitioners had to try and see the situation from the client's perspective. Matt drew on his understanding of trauma from the clients perceptive, "so I guess my understanding of trauma is, [...] something severe that may have happened [...] that has left a significant reoccurring issue with the client" (Matt, P7/282-286). The practitioners' were aware of trying to impose their views onto the clients and were very much interested in the client's perception. In trying to understand the notion of trauma practitioners felt that there was something to be said about

'loss' and what that meant for the individual, "[...] an event that is very traumatic in some way [...] in its purist sense for me probably also encapsulates things like loss" (Victoria, P4/170-175).

Understanding trauma came from an awareness of the intensity of the experience and how it could affect the individual. Chris tried to explain this, but also detached himself from the term, "I think in terms of you know, there is the thing about intensity, intensity of this, this thing called trauma" (Chris, P8/350-351). Lucy also recognised that people can experience the same event, but be affected by it in different ways,

> "I think the intensity would be different yeah or maybe we both experience a near death experience and like a plane crash yeah and on a plane of how many, 100 or 200 on a plane, each of us would probably act differently (Lucy, P3/142-145).

Containing the trauma and putting it into context was important because trauma consumed the client's existence, "something they feel they can't get beyond, that is occupying too much of their thinking time" (Victoria, 7/278-279). Helping the client to come to terms with the experience almost enabled them to find the courage to try and move on and break away from their trauma focussed mind-set.

Use of problem language and labels to categorise

This subtheme highlighted the practitioners understanding of how clients were trying to make sense of what they had experienced. There was often a certain type of language used within this and also 'trauma' was used to try and categorise the experience with very little emphasis on survival; only Victoria referred to this, "[...] put the trauma [...] in to some sort of context,

fortunately she survived and was ok" (Victoria, P20/849-851). Language in some cases proved to be most unhelpful because it had the potential to hinder the growth of the client or willingness to move on from it. Having an understanding of the differences in perception of trauma was important and Chris summarised this quite aptly when he stated, "I think it's in the eye of the beholder really and trauma to one client may not be trauma to another" (Chris, P7/296).

The use of language and labels can have connotations for the practitioner and client. Some of the practitioners avoided putting a label to it because this may have influenced the therapeutic work that took place,

> "In my experience something small can be enough to, to gap, to bring on flashbacks, or, or experiences of distress, so [...] so perhaps haven't always used that label and I guess haven't used it if they haven't" (Matt, P8/314-318)

When working with trauma all practitioners took a non-judgemental stance even when the trauma might have felt insignificant to them,

> "[...] I think it's almost like a label, a category we try to put people into, it makes our form filling nice doesn't it because you are sort of saying well that's that and that's for that" (Ben, P6/242-244)

Although Ben recognised that it can be helpful to put a label to something that clients have experienced it may also seem that clients are being put into pigeon holes by practitioners. This was pertinently illustrated by Victoria, "I suppose in therapy we tend to think the problem, totally defines the person", (Victoria, P13/550-551), where there is a danger of losing sight of who the person is behind the trauma, "it's hard to see beyond it, wait until you've had time to assimilate it and get it in its box" (Victoria, P19/827-829). This is

something all of the practitioners were mindful of because defining the person by what they have experienced could prevent the practitioner from taking a non directive stance, because of the potential for an agenda in therapy where the problem would need to be fixed.

The setting in which the practitioner works can dictate how clients are viewed and worked with. Ben is against the idea of using labels for this reason,

> "it's that notion of identity and authorship, I am a terrible person, I am depressed, I am really not well, it's not about you, it's about how you do" (Ben, P8/317-318)

In some respects Ben is trying to rebel against the system in which he works where clients might be judged on their presentation. He has taken a disapproving attitude to this because he appears to resent the use of labels, which can result in further implications for the client who is trying to make progress. Generally speaking there was a lot of negativity around the use of labels and problem language, this was further emphasised by Chris where he commented on this,

> "I think it's, it's their definition that I would need to work with. I don't carry around with me, because I think the word trauma is, is a sort of a profanity isn't it, you know people use it as you know that was you know a terrible trauma and I was walking along the road and I tripped, I was okay, but it felt very traumatic at the time (Chris, P7/290-294)

Chris is very mindful of working with the client's understanding of what they have experienced. He doesn't necessarily relate to the concept on a personal level because he may not allow himself to believe that such a thing really exists. It would suggest that he is reluctant to acknowledge that trauma can affect most people and this was a view shared by

Lucy, “they name it or label it as trauma” (Lucy, P3/100) who felt that a client can become so absorbed by their problems that they could not see a way out. The term trauma has been overused in society and has therefore lost some of its original meaning, “That person sitting in front of me is not the trauma” (Ben, P14/601). This is something all of the practitioners held in their minds when working with traumatised clients and were cautious of making assumptions about trauma when clients were discussing their experiences, “[...] if somebody said [...] I had a very traumatic experience in my life, I would ask, so if you were having one now how would I know? It’s all about the question isn’t it, that you ask, it’s the perception you might have” (Chris, P7/300-305)

The use of problem language can be so powerful that it almost disables a client who might be unable to challenge the use of language, “But then I would say I don’t even know what depression looks like and I am not sure it exists, well of course it exists it is in the book” (Ben, P17/718-719). Ben feels that identity is really important in trying to help someone to identify with their experience of trauma and also as a means of trying to cope with what they have been through to move forward with life. How the client talks about trauma is a key factor in trying to work with it, “[...] I think a lot of language is used as a short cut, the narrative is more important rather than the description” (Chris, P7/307-308). There was a sense that if the practitioner allowed themselves to be consumed by the problem world they lose sight of what is really going on and equally so did the client, “[...] clients haven’t always used that term trauma” (Matt, P7/307). Equally overuse of the term also had further implications, described as a “profanity” by Chris suggesting that it is a throw away term similar to a swear word with little meaning.

The position of the client – agenda

It was important for the practitioners to be clear about what clients were expecting from therapy, "it very much depends on the client I think and where they are at" (Ben, P6/239-240). Level of engagement had an effect on how clients responded to the process because ultimately it was about what they wanted to achieve from it, "[...] people who come to therapy [...] I would hope because they want to, they don't want to be as they currently are, they want to change something" (Victoria, P18/760-762). The practitioners expressed that many of the clients they worked with attempted to put them in the expert role hoping they would have the answers to their problems. "[...] they want to understand why [...] why do I keep forming relationships with people that aren't suitable" (Matt, P13/531-533). Matt was uncomfortable with being put in the expert role, because in his mind it is a shared experience where the client and practitioner are learning from each other, "[...] depends on what the client thinks is important [...] what the practitioner believes to be true" (Matt, P13/537-538). There was a sense that the clients who came for therapy had the resources within themselves to get through their difficulties, even if they were not aware of it. "[...] faith in the ability of a person to kind of cure themselves really, they (pause) they can do something about their situation themselves" (Victoria, P10/422-425).

The position of the client in terms of where they are in life determined how successful they were in moving on from their problems, some clients were coping better than other prior to entering therapy, "in a way she kind of somehow boxed in this traumatic event" (Victoria, P8/330-332), and some of the clients came to therapy with an agenda because they wanted the practitioner to make everything better; this was something Lucy observed,

> "Well obviously they come here with a single aim is to talk about the problem and thinking, hoping, hoping that […] they would, well the problem would be fixed" (Lucy, P5/232-234)

Lucy found the client's expectations quite humorous because she recognises that the client is almost setting the therapist an impossible task. She is aware of her own limitations and does not pretend to be something she is not. The practitioners also expressed that there is some responsibility on the part of clients to try and help themselves, and this may depend on how much they want to move on from it and of course what secondary gains they have from staying in the problem world. John recognised that adult clients sometimes make therapy much more difficult than it needs to be,

> "It's easier with children, because they get it. They don't become obstructive and won't say "well what do you mean" or I can't imagine that when you're doing the miracle question for example. With adults you have to go back and revisit the miracle question with them sometimes because the first time they just get completely stuck like it's impossible (John, P7/291-295)

It seems that some clients are resistant in therapy, it could be that they have become so embroiled in a problem world that anything moving them away from this paradigm seems overwhelming; threatening their sense of self and ultimately destabilising their existence.

The trauma identity – part of the system

This subtheme reflects the practitioners' feelings that the clients were very much influenced by their surrounding system, such as the people around them or the environment. Chris commented on this, "in the context I am working in it could be a physical trauma "[...] surgery that's gone wrong [...] those sorts of issues" (Chris, P8/323-330). On occasions

clients had no choice but to succumb to a system, but this did not mean that they had no control, "[...] she had no choice she had to have an operation [...] she could have some power in terms of giving herself some control [...]" (Matt, P11/452-456). The power of perception was linked to how quickly clients were able to recover. Ben highlights how someone can delay their recovery by almost becoming a label,

> "So you know someone comes thinking they are depressed, it is more than likely they might still be depressed in 10 years time, but as long as they are doing something different they are managing to get a bit of enjoyment by making it out of the pub (Ben, P7/8306-309)

This might suggest that Ben is not in favour of the diagnoses given to people because they can become overwhelmed by their own thoughts and beliefs and are then unable to break away from them, but that changes can occur if clients make the effort. Part of the system is the discourse that comes with it, which can make clients become too focused on the problem world, so they are unable to see the potential for changes that can occur.

> "[...] we co-constructed to this future 2-3 years ago, before he killed himself, before she actually threw him out, she knew what she really wanted to do, but we got back there in the end and she is making it work for her" (John, P5/210-212).
>
> "So she came very traumatised by that and she well, her whole world, really she is right at the centre of her problem world, she couldn't think of a way out." (Lucy, P3/171-173).

If clients are reluctant to let go of the trauma label and problem discourse, the success of therapy can be affected or has the potential to move at a much slower pace,

> "[...] except the system maintains the order, that's what it's really about, it's not about you know well we just need these kids to act and be what they are; you're depressed, be depressed" (Ben, P17/713-716)

Having worked in an inpatient setting Ben had personal experience of this because he can see how influential people's opinions can be in making someone feel a certain way because they have lost their sense of self. It was important to separate the system from individual identity, "recognise the trauma in terms of the system, rather than it is something to do with them" (Ben, P14/598-599).

1.5.5 A POSITIVE COCOON WHERE GROWTH CAN OCCUR

This superordinate theme encapsulates how the solution focused therapeutic space provided the clients with an opportunity to grow. This theme is explored in relation to four subthemes:

- A different lens – a change in perception
- The co-construction of a new reality through language – connected conversations
- Building resilience through positivity and optimism – the survival instinct
- How much do they want to move on? Maintenance of growth

A different lens – a change in perception

The SFBT space was different to that which clients might have experienced previously, "there are models of trauma aren't there that you can use, not that I have used them" (Chris, P9/353-355); there is an evident shift away from formality and preconceived ideas about what therapy should look like, "I think it's got to be about what's going on in the room [...]

rather than going in there with a preconceived idea" (Chris, P11/474-475). Clients were encouraged to look at solutions through problem free talk and alter their perception of reality, "helped them come to terms with the fact that she hadn't actually killed him [...] it was an impossible relationship and she had to deal with that" (John, P5/184-187).

The perception of the client was an important factor in trying to promote growth and this was something the practitioners focused on because often this needed to shift in order for positive changes to occur, "I want you to notice between now and next time [...] any little glimpses of feeling better, a little better than you are today" (Chris, P12/493-495).

Victoria recognised that aside from the clients becoming consumed by their problems, she too had allowed this to happen, thus clouding her judgement,

> "and my own little definition of him was that he this was a man [...] who suffered with anxiety, stayed in the house, you never go anywhere, do anything, didn't work, hadn't worked for years, had no real life beyond being someone who took a Prozac or whatever his medication was [..] a medical model of, of view of him really (Victoria, P13/565-571)

She recognised that she had become lost in the problem world with her client, "that was quite a wake up moment; well actually you know I am only seeing the problem here" (Victoria, P14/576-577). She found the realisation humorous which might suggest that she was little embarrassed it had happened because at first she was not aware of the process. Aside from the practitioner's perception of the client, the client's perception is also a key factor in growth, "I think, it, the big, the first thing is that they are looking at things from a different perspective" (Matt, P4/172-173). It seems that Matt actively looks for clues that there has been a change in the client's perspective; this would suggest that they have started to move

away from their trauma perspective, "[...]you can almost see them thinking about what they have just said in a different light, in a different way" (Matt, P4/156-158). He also places importance on this because it could be the catalyst for other things changing, once the client can see things differently they are perhaps more open to the prospect of possibilities. Lucy was very realistic about how much change can occur as a result of a shift in the client's perception, she can also appreciate how having a fixed view of a problem can be problematic, having a black and white perspective can cause further problems because this again would feed into the idea that a problem is a fixed truth,

> "There are always many different ways to see it (Lucy, P7/284) [...] Yeah, and you can say it is positivity, you can have a negative way or a positive way to see it or more than that yeah, so and a multiplicity of things (Lucy, P7/286-287)

Appreciating the importance of viewing the problem in different ways can help to increase belief in growth and change, where the client's perspective is not as one sided. Also "listening carefully for certain things that the client introduces that gives you a hook on, onto something more positive in their life" (Victoria, P13/540-543) enables the practitioner to increase the potential for many different ways of looking at the problem; being focused on it only serves to limit the viewpoint.

The co-construction of a new reality through language – connected conversations

The idea of a new reality was created by the practitioner and client where it was important to try and not talk about the problem through the interactions that took place. Matt remarked on the suggestion that some clients are really keen to engage with the formation of a new reality, "I guess it seems to work for some, like some really get that" (Matt, P4/153-154) and the use

of scaling might help with this, "[...]taking time to really consider that" (Matt, P4/173-175) . Victoria felt that the role the practitioner took in trying to co-construct a new reality came from working collaboratively, "[...] rewriting together a kind of future scenario thing, through things like the miracle question and all of the ideals, sort of life that the person wants to have" (Victoria, P4/163-165). Victoria highlighted the importance of this because the client won't always be aware of the potential for positive change. Lucy could also relate to the feeling of trying to listen to the problem in a different way and again this was very much a conscious process for her,

> "We listen to the problem differently as well, obviously we listen to the problem the client comes here for, so we listen, we listen out to within their description of the problem, we listen out for exceptions, extremes, and habits, coping strategies" (Lucy, 6/242-245)

Even though the practitioners are working from a SFBT standpoint they also recognise that the problem exists for the client, but that despite this they are still functioning, "Waiting for them to give you clues as to how they are actually functioning" (John, P2/53). John gives the impression that he is a detective trying to look for clues in the client's story. It isn't always obvious, so it suggests that the practitioner has to be fairly skilled in trying to spot these. It was also important to present the idea that the client was perhaps functioning better than what they might have thought,

> "People were living lives that were quite often okay, the areas they were really functioning in and rather than digging for material which really just supported the predicament that people found themselves in" (Chris, P5/207-208)

The therapeutic process the client and practitioner went through was the most important thing because they did not place as much emphasis on the end result,

> "The outcome is never the outcome in solution, for me as a solution focused practitioner I am not bothered about the outcome, I am more bothered about the process to which the client goes through in order to get to their suggested outcome" (Ben, P6/223-227)

Ben implies that the outcome is not important for the solution focused practitioner and that the process is where growth can occur establishing a connection in the therapeutic relationship can help the client,

> "It's really about, about talking to people in a way, in a way that you can connect with them and I think you know if you can connect with them then you will get along with them, you are halfway there" (Chris, P12/525-527)

Although the solution focused practitioner encourages the client to think about aspects unrelated to the problem, there was also great emphasis placed on the quality of the therapeutic relationship. This was something all of the practitioners felt were important in trying to enable the client to make positive changes. Chris felt that the use of language was important in doing this because through that you can connect with the client. It also suggests that he felt that a client would be more likely to respond to the approach if they were able to get on with the practitioner,

> "You, it's you know, it's a lovely chat we've had today and now if somebody goes out and says that was really interesting and I really enjoyed being here today it's not about me feeling good about it, it's about the fact that I can have a conversation with someone [...]" (Chris, P12/485-488)

Having this rapport in some ways makes the practitioners' job easier because the client may then be more likely to engage and respond to what the practitioner is suggesting or exploring

whilst building confidence in their ability to cope, "[...] I was just using solution focused language to help them to understand that they were actually coping better than they believed they were" (John, P1/41-45). Lucy felt this was necessary because once the client was an active agent in this process they were more willing to try out a new discourse with a different style of language,

> "So really we shift her attention, well not only her attention away, but position her into a position where from one, shall I say a discourse of her describing the problem world into another discourse" (Lucy, P5/188-190)

Lucy felt it was important to try and perhaps use distraction techniques to encourage the client to redirect their attention away from the problem because she felt that whilst focused on this they would be unable to even contemplate using a new discourse/type of language. Taking time to consider the other aspects of the clients life helped them to, think about other areas of their life, "one bit of the jigsaw, but that it's trying to move away from that one little bit isn't it, to get some insight into the other aspects of the jigsaw puzzle" (Victoria, P13/547-548).

Having a strong therapeutic connection enabled the practitioners to try and encourage clients to consider life in a more balanced way; however despite this they were also conscious of seeming insensitive, "Well it's about being respectful and subtle in the language you use" (John, P2/51). Taking experience into account it was also suggested that the use of the therapeutic interventions was important, like "positive affirmations, lots of problem free talk about what she liked doing" (Victoria, P9/374-375). However Lucy suggested, "It is not about the techniques, it is only the expression "[...] well techniques are really tools we are using" (Lucy, P5/216-219), because of their intended purpose to evoke movement.

Building resilience through positivity and optimism – the survival instinct

The practitioners all noticed how resilient the clients were as they entered therapy, which is something that could be built upon. Victoria felt that the crux of it was the fact that SFBT is essentially optimistic, "I think it is essentially optimistic; it's essentially forward looking, future looking, upbeat" (Victoria, P10/431-433).

SFBT is different to other therapies because it does not dwell on the past and encourages growth by looking to the future. Despite the preference for looking to the future, it was also recognised that reflecting on the past was helpful in facilitating growth,"[...] empowering the client to see what they are already doing that works [...] been amazed by the fact they might have had a difficult childhood [...]" (Matt, P9/352-357). Matt could appreciate how important it was for the client to recognise how far they had come since experiencing trauma. All of the practitioners could identify where client's had grown as a result of trauma, this was something that was nurtured during therapy and the process may have already started before that had even entered therapy.

> "She is very successful; she is an occupational therapist now" (Ben, P12/497)
>
> "Why is it, well because, because that really enables them to really see life really is happening anyway beyond, or away from the problem, they are doing already, they are doing very good" (Lucy, P8/336-338)
>
> "Her strength, a lot of affirmations about her qualities if you like, her ability to cope with this, this trauma and how well she had coped with it and managed it" (Victoria, P9/370-372)

> "[...give themselves credit [...]seeing that as something positive, rather than focussing on why do I keep doing this, what's wrong with me" (Matt, P9/366-369).

> "Just, being respectful in what they had achieved and how they were managing to hold it together, like the suicidal client that, she had not committed suicide and she had done so many things" (John, P2/68-70)

> "[...] the way I would work with people who are in recovery is to invest in them to some degree [...] of strength and the ability to actually move on and move forward" (Chris, P6/237-238)

When talking about the process of growth, similar to that of trauma the practitioners felt that it meant different things for different clients. It was also humbling for the practitioners to observe how clients often when in the face of trauma did not recognise that they had managed to get themselves through it. There was some derision of therapies that were different to SFBT in terms of promoting growth. "SFBT gives you the opportunity to step away from all that and actually work in a structured way, but in a way that makes a difference" (Chris, P7/275-277). It highlights the point that the person is really the expert on themselves and despite experiencing trauma will have been able to hold onto some normality or identify something they have done to keep going, "Trying to understand how people are disabled rather than enabled" (Chris, P15/649-651) and "well and I am not suggesting that, I am not suggesting that psychologists or anybody else disabling people, but some of the work that gets done, does it disable people?" (Chris, P15/-655)

It seemed that practitioners had quite a critical view of therapies which in a sense might disable the person, making them feel like they needed therapy to be able to cope with what

had happened. To not take into account how strong a person could be even without therapy could undermine their own ability to cope,

> "I am dealing with highly professional nurses who have dealt with the workings of the human body laid out in front of them…there is a certain amount of resilience there to start with" (John, P11/471-473)

In the setting in which the practitioners worked they came across very resilient people. Admiration was shown for the client's ability to do the things that they did and the practitioner was able to build on the resilience the client's already had, "[...] affirming for someone to kind of say well actually I have got skills and resources and inner strength" (Victoria, P10/461-464), which might suggest that a certain type of person might respond better to SFBT than others.

How much do they want to move on?

All of the practitioners felt that the key to growth and maintaining it was dependent on how much the client wanted it. Victoria aptly captured the essence of this, "I think that's the key to ongoing growth really, vigilance and monitoring the situation yourself" (Victoria, P16/697-698). Practitioners recognised that clients had to make a conscious effort to make changes and want to move on with their lives, "in the early days of working with trauma that's what you need to promote, "the fact that yes in life we have trauma, but the possibilities are there because we do move on, we do have days when we forget" (Chris, P10/427-430). It was almost indicative of the belief they had in themselves, which was explored in therapy, "[...] how will you know when you have recovered, how do you know, how will you know when you don't want to see me anymore" (Chris, P10/437-443). This process of exploration was a cognitive process where the client had to become a conscious agent of their thoughts regaining control, "and mainly darting their own thoughts you know,

you know where you are wondering back to some, to some gloomy thoughts or stuff that, that doesn't serve you well" (Victoria, P15/689-691). Keeping a positive mental attitude could help maintain growth, "[...] lots of clients I have worked with to some extent have been able to grow and grow stronger as a consequence of something that might have happened" (Matt, P8/327-330).

To try and capture the essence of post-traumatic growth, a metaphor was used by Ben to illustrate this,

> "What we are suggesting is well you fall off your bike, you pick yourself back up, you get back on the bike, you have grown, that's post traumatic growth" (Ben, P9/394-396)

This suggests that there is some willingness on the part of the individual to pick themselves up and carry on and it also means that they learn from this experience in order to move forwards. It is interesting how Ben uses this metaphor to suggest that someone who has experienced trauma will be similar to that of a child falling off a bike when they are learning to ride it. It is almost like they are susceptible to vulnerability when in that moment, but that they can almost learn from that experience and prepare themselves should something similar happen again. He also suggested that there was a specific typology that went with the notion of growth, "typology that goes with it and the notion of growth of course being about a different type of philosophy" (Ben, P9/390-391).

Lucy touched on the motivation/determination of the individual. She felt differently to Ben because she recognises that if post traumatic growth was to occur then the client would need to take action,

> "She wants to do more, she will go, well that's what she did anyway, she will go home and exercise that, exercise the do more and repeat, the nice feeling, the feeling, the feeling that she got from that experience" (Lucy, 9/370-373)

It seems that Lucy is a practical person because she believes the client should regain control by taking action and by making a commitment to do more. Taking an inactive stance was not encouraged by practitioners because this prevented the client from connecting with the experiential stuff; experiencing the positive emotions from the positive behaviours, "[...] it's about stepping out of that and saying I will go away and try that and come back and want to talk about it and I think that's how you maintain it" (Chris, P14/611-613. John also encouraged clients to draw on the support from their surrounding network to maintain growth, "it's not just me that's helped them, I have helped them to rely on the other people in their lives [...] (John, P6221-225).

1.5.6 THE LONGEVITY OF THE APPROACH – A SMALL FISH IN A BIG POND

The superordinate theme 'the longevity of the approach – 'a small fish in a big pond' encapsulates how practitioners felt about SFBT in terms of how likely it is to survive in a society where other approaches are somewhat favoured.

This theme is explored in relation to four subthemes which are:

- Spreading the word
- Striving for acceptance
- Moving with the times – a growing need for brief therapy
- The pitfalls of the approach – things to be cautious of

Spreading the word

Most of the practitioners who were experienced in the use of the approach were clear about trying to spread the word about the effectiveness of the approach in this field and were active in this process. Lucy recognised the importance of encouraging other professionals to utilise aspects of the approach in their working practice, "[...] social workers, well they are obviously not counsellors, but they still have interactions with, well they use the solution focused approach' (Lucy, P11/448-451).

In contrast it was suggested that there was an insular perspective taken by people with little knowledge of the approach because there were some misconceptions about its application and that the closed nature of the conferences being held for solution focused practitioners did little to promote its use in the wider field,

> "You only have to look around our little neck of the woods, you come to our conferences and go to bits of [...] and you're doing the course and at [NAME REMOVED] you realise it's not particularly fashionable" (Ben, P1/34-36)

He suggests that SFBT is very contained and almost closed off from the rest of society because it hasn't been united with some of the more popular approaches. He suggests that it is not fashionable to be studying SFBT because it is different. He also feels that the approach does not help itself with this because the effectiveness of it is not really talked about; he illustrates this by saying,

> "I think CBT has got a bigger mouth, seems to be getting better results, seems to be doing this, seems to well have you noticed I use a lot of seems" (Ben, P7/266-268)

Ben tries to infer that on the surface CBT is seen to be working well for clients, but in reality he is doubtful of this and does not trust that the approach is all it is meant to be.

There was an evident lack of promotion and training in the SFBT field, but some practitioners had tried to tackle this issue singlehandedly, "I used to do quite a bit of training in SFBT management course you know" (Chris, P5/183-184". It highlights the fact that there is a huge void to be filled in terms of promoting the approach and an opportunity is being missed to try and encourage groups of professionals, like counselling psychologists to get involved with the approach by applying it to their client work,

> "Interestingly I have never formally studied it, I have kind of done, counselling certificates, masters in counselling psychology and now doing a doctorate at the moment and you, never really had a module on solution focused therapy" (Matt, P2/96-99)

Matt felt it was important to share his concerns, however what is encouraging is that the approach is being promoted in specialist academic modules, "[...] I have done a module on working with couples and families and there is lots of solution focused models there." (Matt, P2/110-111). Despite the lack of training Matt is proposing that he can work with the approach. This in some respects downplays the importance of training in this type of therapy; it suggests that training is not essential and that anyone could perhaps work with the approach if they had the right skills and enough knowledge to get by.

Striving for acceptance

The experienced practitioners felt that in some respects they really had to make a conscious effort to be noticed by services that command the process and consequently make

recommendations for SFBT; it proved difficult in many respects, "CBT is flavour of the month at the moment and everyone wants CBT" (Chris, P9/357-358). There were also misconceptions about what SFBT could provide, "[...] there are still issues around the whole idea that we are skimming over the real issues that the clients have [...] and that we are not meeting those in depth needs" (Chris, P1/38-43).

Some services were very precious about their clients and had hidden agendas where they were keeping clients for themselves despite the fact that the client might have responded better to SFBT,

> "So they are not referring anyone to us, so we have a shortage of clients, that we can't make our targets because they are not referring clients, they are keeping them for themselves and pushing them through group work" (John, P13/542-555)

John was obviously concerned by this because the success of the service very much depends on the number of referrals received and the number of clients worked with. There is a sense of frustration on his part because of the increased pressure on practitioners exposed to contextual issues and politics where the emphasis is taken away from the client, particularly in specific settings, "it is just about getting past the CBT mafia as we call it at the top of the NHS" (John, P14/583). Interestingly some of the hostility directed towards SFBT comes from organisational politics; however some of it also comes from individuals choosing to work in certain ways,

> "That's where I am at with my practice because it falls down on a lot of deaf ears because my colleagues, my colleagues would be going that isn't gonna help (Ben, P3/100-102)

There is a sense that he is saddened by the lack of respect that SFBT has and in his work setting it almost feels like he is the minority. SFBT has a lack of power in that it struggles to spark peoples interest, "I suspect we are a minor player we, we are fighting among ourselves on the whole" (Ben, P14/613). However, despite the lack of interest in the approach it was felt that there might be more of a place for it within the field of counselling psychology,

> "[…] I am surprised that counselling psychologists haven't taken it up more" (Matt, P15/632-633) and "I think counselling psychologists are in an excellent position to be able to use those solution focused skills and techniques and interventions in a way in which they are still staying true to, to the values of counselling psychology and you know being with the person in the room, so seeing that person as a person and paying attention to the therapeutic relationship" (Matt, P14/597-601)

He separates counselling psychologists from the existing population that might already be using SFBT because to date it is yet to take off in the field of counselling psychology. This was further illustrated by Ben, "it is all brand new to them, so what we are doing really is building a little epicentre" (Ben, P3/148-150). The identity of the counselling psychologist compliments SFBT, "we know the skills of different theoretical models and can apply those in a sensitive way and in a way that is unique to the individual client" (Matt, P14/607/608). He might be justifying his position and reinforcing how he is able to use it to enhance his working practice.

Moving with the times – a growing need for brief therapy

Practitioners felt that SFBT had its place in modern society simply because it is brief and it is effective, this was illustrated by Lucy, "[...] we want to make it short, it is the type of approach, the vey approach we use that enable client to move forward, faster" (Lucy, P5/203-205) and Victoria, "that seems to be quite the norm, two sessions, I feel a bit guilty, I've got someone coming back for a third session" (Victoria, P7/297-299). In comparison to a lot of approaches it can achieve post traumatic growth in shorter space of time, where some clients only receive a maximum of 2 sessions making therapy very focused.

> "The pressure is on there to do a more focused block of work (John, P13/550-551 [...]they are going to have to pay, because it is going to help you focus your work and help them to focus the work as well and it is working" (John, P13/555-557)

John could sense the pressure that practitioners face because they need to be seen to be achieving positive results. He also felt that paying for therapy would help practitioners to be more focused and that SFBT could fit into the world of counselling psychology because it is brief,

> "Well I think in terms of counselling psychology is where they are working, if they, if they have economic pressure put on them I think solution focused can save their bacon, that's what they are calling for" (John, P14/586-588)

In the current economic climate SFBT could come to the rescue of counselling psychology, especially if there was a requirement for therapy to be brief. Practitioners felt that they would recommend this approach to someone requiring short term therapy,

> "Certainly in my experience particularly for short term work I would definitely use this if somebody said I've got this issue and I can only afford or got time to, to have to have five sessions of therapy what would you recommend I would say solution focused" (Matt, P13/547-550)

Matt obviously feels that the approach has strengths in terms of the fact that it is short term and that it would work out cheaper for clients. He is loyal to the approach because he can see that it needs to be promoted in certain professional fields and it is encouraging that he chooses to share this view with people that might be interested.

The pitfalls of the approach – things to be cautious of

All of the practitioners were positive about the approach, but were not biased in their ability to identify things that might influence its effectiveness. There were concerns expressed about trying to integrate the approach with an approach from a different philosophical standpoint and this was something illustrated by Lucy, "[...] they believe different things [...] it is harder to mix the two" (Lucy, P11/462-466). She also made reference to working from an eclectic position, but ultimately there was a sense that SFBT should be used in a purist fashion to achieve the best results. This was further supported by Ben who remarked on the significant difference between the philosophical underpinnings of CBT and SFBT, "[...] CBT is based upon the notion of authority and power [...] we are applying a different notion of philosophy [...]" (Ben, P7-9/280-399). The application of the techniques could be applied in practice, but aligning oneself to either approach would mean taking on the positivist or social constructionist philosophy. The lack of regard for the different philosophical underpinnings was further illustrated by those who wanted to relate SFBT to CBT, "people would say it

sounds a bit like CBT to me, you have got to fit the model in order to actually work with people" (Chris, P5/216-218).

Some of the practitioners were disappointed in the lack of development and movement, Ben summarised this where he felt that in a sense practitioners using this approach had failed to take it further by building upon what had already been found.

> "if De Shazer was still alive now and come back in a space ship he would probably be looking at us going what, it has been 10 to 15 years 10 to 5 years how come you haven't, why aren't you doing nothing different" (Ben, P2/81-85)

The lack of movement with the approach is also something that Paul identified with; he illustrated this by saying,

> "There are new ways of actually working with SFBT rather than just spoon feeding it and then you know well quite often when I am teaching people you know they talk about you know the sort of bits of the model that everyone is familiar with now like the miracle questions and I am quite interested in developing other ways of actually working with people" (Chris, P6/221-226)

There is also some frustration on his part because he has grown tired of spoon feeding the approach and although he is still imparting knowledge through training has now recognised that he wants to develop it further. He may recognise that the approach needs to move with the times and if it is going to stand a chance against some of the more established approaches it will need to be taken more seriously. Matt tried to identify some of the reasons why the approach might not be favoured in the therapeutic field,

> "[...] it hasn't been well researched [...] it's not well taught or extensively taught in universities [...], it's kind of going with what the evidence suggests which tends to be CBT because, because of its strong research emphasis really" (Matt, P15/635-645).

There is a sense that the approach has let itself down because it is not evidence based and falls short when compared to approaches like CBT with a strong evidence base. This was especially the case when trying to capture outcome in specific settings, "[...] they have to fit in, they have to fit in the zone for caseness to be entered onto a database" (John, P13/560-561 and "[...] they come in for their first session and they are out of the zone that isn't counted" (John, P13/563-566). Matt also goes onto talk about the reasons why some people might not respond to the approach,

> "So I think the danger of solution focused is if you choose to I guess looking at, kind of psychological bulldozing in a way [...] the danger is then that you don't, the client doesn't feel heard or listened to and that trauma is not acknowledged and its always then well how did you manage to keep going" (Matt, P11/470-471)

Matt shows that he is fearful of the client feeling that they are not being listened to. His opinion of SFBT is fairly negative in that he used the term, "psychological bulldozing" to suggest that it has the potential to cause further harm, with little regard for the client, "[...] every technique is probably disastrous in the wrong hands" (Ben, P12/503-504). Furthermore, Matt suggested that the style of questioning used by the practitioner may cause problems,

> "I think the problem potentially can be that it becomes question answer in solution focused therapy and it kind of becomes a bit of then what, then what, then what and you are kind of looking for exceptions what else what else what else…(Matt, P13/557-560) [...] "but all the follow up prompts that go with it, it, it to me it, it can, has the danger of being a bit like a machine gun where it is just firing questions at me" (Matt, P14/577-579)

Matt highlights the danger of asking too many questions where he uses a metaphor: "machine gun". This also gives the impression that lack of experience might make a practitioner more susceptible to using questions rather than just being in the moment with the client leading to misconceptions about the use of the techniques. This point is also supported by Victoria's feelings about the approach where she stated,

> "[…] I don't feel I know enough about solution focused or practised long enough to kind of make a sort of sound judgement because it's more like a gut instinct stuff really and I suppose that I would be quite worried about, I would probably be worried about using any generalised approach for something as, as kind of radical as those kind of events because there are very specific interventions aren't there" (Victoria, P5/192-197)

Victoria is aware of her lack of experience and this is reflected in her concerns, "as a complete novice I suppose I wouldn't be comfortable in using that approach with a severely traumatised person" (Victoria, 19/833-835). She highlights the importance of the role of an experienced practitioner, "I think it's being skilled enough to use them in a timely way" (Victoria, P11/469) and "I don't think it's anything to do with the techniques, all the techniques are absolutely valid and useful. I think you have got to [...] know each other if you

like and for the client to kind of invest some trust in you." (Victoria, P12-14/520-615). She has faith in the approach and is aware that it can work if the client recognises that the practitioner has their best interests at heart and trusts that they are in competent hands.

It is important to note the misconceptions around the approach, shared by the practitioners with very little experience of it to those who had a lot of experience. As an experienced practitioner using SFBT Chris suggested that people had an inaccurate idea of what the approach could offer implying that society leads us into thinking that clients should be treated for complex issues, like bereavement, in a certain way,

> "I think that working with, in with people who are bereaved is quite a tricky area in itself and I think you know that while there are things you quite often hear about in SFBT you know it's all about positivity, except when it's not" (Chris, P6/7264-267).

Bereavement is seen as a difficult issue to work with in therapy typically and it is noted how SFBT is perhaps considered to take an insensitive approach to this complex issue, however drawing on experience of the application of SFBT to bereavement instils confidence in practitioners for the way it can work.

1.5.7 Summary of results

To conclude this section the research question underpinning this study is: "What are the experiences of solution focused practitioners' in the facilitation of post-traumatic growth during brief therapy?" Four major themes emerged from the data providing rich and valuable insight into the experiences of the practitioners using SFBT in their working practice: (i) Who am I? – Becoming Solution Focused; (ii) A problem world where trauma exists; (iii) A positive cocoon where growth can occur; (iv) The longevity of the approach – a big fish in a small pond. The themes are interwoven because they offer an understanding of the journey undertaken by the Solution Focused Practitioner on a professional and personal level; recognition of a world involving problems; the importance of an SFBT therapeutic space; and the potential future of SFBT in the field of trauma therapy. These findings will be explored further in the wider context of the research literature in the following discussion.

1.6 DISCUSSION

1.6.1 OVERVIEW OF THE RESEARCH

The purpose of this research was to explore the experiences of SFBT practitioners facilitating post traumatic growth during brief therapy. *Firstly* to try and understand how the practitioners made sense of trauma, and *secondly* to find out how they could help a client to experience post traumatic growth through the use of SFBT, specifically over a brief period of time. There is a lack of research exploring the significance of this approach in the facilitation of post-traumatic growth. It is hoped that this study will contribute to the research that has been conducted thus far and perhaps promote further research.

The discussion will aim to examine the results obtained in relation to the literature; will discuss the implications of the findings for practice; explore the limitations of the study and make recommendations for further research. The findings are one possible interpretation of the solution focused practitioners' experiences of facilitating post traumatic growth during brief therapy and will not reflect all possible explanations available. The results will show how practitioners' working from an SFBT perspective can help a client to overcome trauma in a positive way and highlight how assumptions held by a practitioner can influence the way therapy is conducted, not only due to the experience and skills of the practitioner, but because of their philosophical position which influences their interactions with clients.

1.6.2 Perception of reality and use of language

Social constructionism held a significant role in the results because participants referred to the philosophical underpinnings of SFBT and how it differed to approaches positioned in another philosophical position; how it influenced their work with clients during application;

and how it influenced their way of being professionally and personally. In the social constructionist perspective the only reality that can be shared in therapy is the world that is co-created by the practitioner and client through the use of language (Rudes & Guterman, 2007). Gergen and Gergen (2004) argue that the 'inner world' of a person is the most central part of our being, because it is where the creation of a world involving separation, isolation and conflict takes place. There is a great deal of emphasis placed on the role of the practitioner who attempts to understand social constructionism requiring them to take an epistemological leap because the language used to understand is instead related to the 'individual tradition' (Bruner, 2004; Gergen, 1985,1997; Gergen & Gergen, 2004). Rudes and Guterman (2007) clarified this further by stating that the language used in relationships allows access to inner subjective experiences, where familiarity with each other through contributions shared can be achieved. In this study practitioners allowed the researcher into their subjective worlds and an example of insight was shown by one practitioner, "the natural thing certainly for me is, is to kind of think about what's gone wrong, what haven't they got, rather than what they have, so it's, it's almost like kind of how we socially construct stories and it's, it's easy to look at the half empty rather than half full'. It seemed that there was conflict between trying to make therapy easier by focussing on problems, which came naturally to the practitioners due to previous training perhaps, and from the challenge in trying to understand the clients' subjective experience of trauma by paying close attention to their spoken language.

Our perception of reality is demonstrated through use of language, which is influenced by the media. According to Baudrillard (1988); one of the key figures in the postmodernism debate, argued that the influence of the media on our perception of reality now operates without having to make a necessary reference to reality, because it is pure 'simulacrum'. Baudrillard

suggests that society is obsessed with images, which only serve to fundamentally alter our perception of the world and the representations of what reality should look like; experience can only take place at a 'remove', where experiences of the world only occurs through a filter of preconception and expectation fabricated by a culture that has been saturated with images (Ward, 1997). This was a view shared by practitioners who became aware that the clients they worked with had a very different perception of trauma, when compared to their own perhaps, "It's that acuteness, it's about the families in distress, the breaking up because of drugs and stealing cars and poverty and all of that usual stuff that makes good TV". Ward (1997) discussed how Baudrillard's analysis of society was influenced by Plato, where it is assumed that the world of eternal ideal 'forms' lie beyond the world that we see. Plato used an analogy to compare ordinary people in daily life to prisoners trapped inside a dark cave watching a shadow puppet play on the walls. Plato argued that people have not been able to escape the cave, so we believe that what we experience inside of the cave is the real world. Baudrillard accepted this analogy by suggesting none of us can escape the cave and that we will continue to be influenced by the systems to which we belong (Ward, 1997). In a sense the practitioners also related to this analogy because they discussed the use of terminology in specific settings and within these cultures how perception often influenced how clients were treated, "the system maintains the order, that's what it's really about, it's not about you know well we just need these kids to act and be what they are; you're depressed be depressed".

The use of language was defined as fundamentally more social and available for scientific study, which evolved through the 'structuralist' movement because it allowed for insight into both conscious and unconscious meanings and motivations (Strawbridge and Woolfe, 2003). Over time 'structuralism' then became a focus of critique and 'post structuralism' emerged relating to a broader movement of 'post modernism', where it is maintained that language and consciousness are related in favour of smaller systems of 'discourses' which can be

found in the specific forms of social relationships (Strawbridge and Woolfe, 2003). This research study is positioned in the post-modernist movement because it is concerned with the systems of discourses that are shared between the SFBT practitioners. However, the deconstruction of meaning which stems from 'structuralism' is also important because although the study is positioned in the post-modernist movement due to its alignment with social constructionism, there are aspects of the 'structuralist movement' present in the information discussed by the practitioners. This was evident through the deconstruction of the meaning of trauma in order to make sense of the experience from the client's perspective. Ward (1997) discussed how structuralism deliberately plays down any notion of the content of a text (which in this study could be the notion of trauma) in relation to Derrida's (1997) argument about the design of structures, which appear more clearly when the content (which is the living energy of meaning) is neutralised. What became apparent from the practitioners' experiences of facilitating post traumatic growth was not the outcome of SFBT, but the process the client goes through to reach growth. An example of this came from one of the practitioners, "The outcome is never the outcome in solution, for me as a solution focused practitioner I am not bothered about the outcome, I am more bothered about the process to which the client goes through in order to get to their suggested outcome." 'Structuralism' is therefore about the formalities of 'how' texts mean rather than 'what' they mean because it explores the relationship between language and knowledge (Ward, 1997). Heidegger (1975) argued that, 'language speaks us' and from this came three main structuralist themes influencing the development of postmodernist thought (Ward, 2010). It was suggested by Heidegger that; *firstly* 'we use language to organise and construct reality', which for the practitioners in this study meant that language constructs an identity within a system, "It's that notion of identity and authorship, I am a terrible person, I am depressed, I am really not well, it' not about you, it's about how you do" [...] "But then I would say I don't even know

what depression looks like and I am not sure it exists, well of course it exists it is in the book". *Secondly*, 'meanings happen only in relation to structures – no single thing 'gives off' meaning of its own accord, it does so only in its relationship to other things'. One of the practitioners discussed the meaning of trauma, where their sense of it came from their supervisory relationship rather than gaining an understanding of it as a concept in its own right, "so I guess I have kind of understood it as trauma and that might have been something I have taken to supervision…or my supervisor has said it sounds like that has been a traumatising experience". *Thirdly,* written and verbal language provides the clearest demonstration of these structural or relational properties and studying how language works can provide an understanding of how all cultural products create meaning (Ward, 1997). The practitioners did not impose their definition of trauma on clients, but were able to consider how the trauma language worked for them because it came from a culture of problems.

A modernist view of language has been shunned by the solution focused perspective where it has been presumed that language is a representation of the individuals internal mental constructs, instead the approach is based upon a postmodern view (social constructionist) of language in which this medium of communication is a way of exploring social realities (Chang & Nylund, 2013). Social and interpersonal factors influence human existence as we know it (Gergen 1985) and it is understood that we gain our sense of reality and what we believe to be true from the interactions we have with other people, hence why an understanding of subjective experience, a client's worldview and the nuances of their inner world was considered to be vital to therapy (Hansen, 2005). The importance of conversations was highlighted in this study and it was recognised by practitioners that avoidance of being directive during the interactions that were facilitated, enabled them to feel more relaxed about what a therapeutic conversation could involve, "it's not about me feeling good about it, it's about the fact that I can have a conversation with someone [...]". The importance of gaining

knowledge is recognised as means of exploring the intersubjective communication patterns that occurred allowing for greater insight into the clients world, not to be seen as an objective representation of what reality should look like (Rudes & Guterman, 2007). Gergen (1985) also remarked on this where it is argued that knowledge is the, "result of an active, cooperative enterprise of persons in relationship." (p. 267). Knowledge of the client's experience of trauma was achieved by the practitioners because they could recognise where it had come from, but the subjective view they had of what reality should look like without trauma was facilitated by moving the client into a discourse away from problems, "So really we shift her attention, well not only her attention away, but position her into a position where from one, shall I say a discourse of her describing the problem world into another discourse". Communication researchers McGee, Del Vento and Bavelas (2005) discussed how the creation of a new common ground is developed between the practitioner and client where there are various assumptions held about the client embedded in the questions that are asked, allowing for a process of discovery where the client can construct themselves in ways that would help them to lead a more satisfying life. Theoretically change is either constrained or enabled through the interactions that take place in SFBT and problems and solutions are not necessarily there to be discovered in reality, but are constructed through the use of discourse between the client and other people in the client's world (Cavanagh & Grant, 2010; de Shazer, 1988; O'Connell, 1998).

1.6.3 Notion of self – thinking philosophically

The ideas around 'self' were explored in relation to the post-modernist movement discussed by Lyddon (1998) in the paper; 'social constructionism on counselling psychology: a commentary and critique'. In this paper Lyddon challenged the modern view of the self,

which was seen as a separate entity from the social world. However, it is now recognised that the self can be influenced by social factors. Furthermore, Lyddon (1998) also suggests that the self can be influenced by other factors, including; cultural and political influences. In this study practitioners held the view that clients were influenced by their social world because they were expected to fit into a category where their problems could be diagnosed and treated. It was also a means of trying to measure the success of therapy because of the influence of the political agenda where capital has been directed into therapies that can achieve the quickest results. "I think it's almost like a label, a category we try to put people into, it makes our form filling nice doesn't it because you sort of saying well that's that and that's for that." These influences also challenged practitioners in terms of how they understood the client's agenda because instead of isolating psychological problems, such as trauma within the client, taking a social constructionist view showed how this cannot be separated from social processes and context (Lyddon, 1998). This view was favoured by the solution focused practitioners because it challenged their perspective on life, of the notion of the self and of trauma. It seemed that the practitioners had become dissatisfied with the conceptual aspects of previous training courses and were drawn to SFBT because of its social constructionist underpinnings. Trying to understand the individual was achieved by looking at how the client could be enabled to make changes for themselves, whereas disabling clients into thinking the practitioner held responsibility for changes that might occur was ineffective, "Trying to understand how people are disabled rather than enabled" and "well and I am not suggesting that, I am not suggesting that psychologists or anybody else disabling people, but some of the work that gets done, does it disable people?". The social constructionist principles as argued by Lyddon (1998) do not lend themselves to a set of values in a profession grounded in psychology for example, however it was further suggested by Lyddon that in counselling psychology practitioners who are orientated to a social constructionist

standpoint already adhere to certain values in practice and find that the social constructionist epistemology is harmonious with those values and practices (Lyddon, 1998). Although not all of the practitioners in this study came from a counselling psychology background, they were aware of the significance of their values in terms of how sessions were facilitated, "not bring ourselves really, what we believe, or what, our value system as solution focused practitioner drive the session." Furthermore, the practitioners along with the researcher although aware of the influence of systems in the individuals' world, how these can affect perceptions of life and the notion of power for example, where it is suggested that the client is the expert, are able to reflect a value laden interpretation of what the counselling relationship should look like (collaborative and empowering) (Lyddon, 1998). One of the practitioners remarked on this, "I think counselling psychologists are in an excellent position to be able to use those solution focused skills and techniques and interventions in a way in which they are still staying true to, to the values of counselling psychology and you know being with the person in the room, so seeing that person as a person and paying attention to the therapeutic relationship."

Once practitioners had become embroiled in a solution focused way of thinking there was no need to return to the traditions they might have been trained in. Aside from the recognition of why the various philosophical underpinnings influence working practice, differences were also shown in how therapy was conducted because this was a demonstration of the application of values and beliefs in reality. The identity of the researcher as a Trainee Counselling Psychologist made her conscious of the influence of a traditional way of working with clients because the opposing assumptions of problem focused approaches would cause further conflict for the practitioners trying to work from a SFBT orientation. It is understood that counselling is rooted in humanistic and existential-phenomenological psychology; the search for meaning and understanding is integral to this tradition because there is a focus on

the subjective nature of the experiences of clients with an understanding of values and beliefs (Strawbridge & Woolfe, 2003). In contrast psychology is rooted in experimental behavioural science evolving from a 'scientific revolution' where it was argued that knowledge should be based on 'objectively observable facts' grounded in empirical research stemming from a positivist philosophical framework (Strawbridge and Woolfe, 2003). Visser (2012) argued that the decision not to return to previous training might come from the suggestion that in contrast to other theoretical standpoints SFBT practitioners view people as autonomous and competent with a desire to "do good"; leading to the formulation of three statements: 'people prefer to make choices for themselves', 'people prefer to be competent and people want to have and build meaningful relationships' and 'make a positive difference'. With these assumptions in mind practitioners reported making a conscious decision to move away from a scientific understanding of clients in psychology. In this research it would seem that the participants were very aware of the dangers of holding a heavily biased scientific view, which did not compliment how the practitioners wanted to work. "[...] all we were doing was applying understanding, so applying theory or yeah, applying theory or understanding [...] actually I wanted, was some new insight, an area of knowing or talking about the human condition really." Effectively practising SFBT and as supported by Visser (2012) is likely to change the practitioners view on people and point them in the direction of solution focused assumptions that form the basis for the therapeutic work they do. This was supported in the research because practitioners became aware of the influence of knowledge gained from other orientations, which caused them to make inaccurate assumptions about the client's needs. Awareness was the key to positive changes in working practice because it enhanced their way of being with clients, "that was quite a wake up moment, well actually you know I am only seeing the problem here".

Chang and Nylund (2013) argued that SFBT practitioners assume that people tend to take the constructive path because they are drawn to positive and helpful ways of doing, suggesting that their assumptions about people reflect the universal basic needs of: autonomy, competence, relatedness, which have been identified in the Self Determination Theory (Deci & Ryan, 2000), which is a macro theory of human motivation and personality. It seemed that the client's agenda for therapy was linked to the self-determination theory because they were motivated to try and come to terms with the trauma experience because as said previously there was a level of resilience in their personalities that enabled them to do this. Practitioners were aware of this because of the desire the clients had to do something to change their situation, "She wants to do more, she will go, well that's what she did anyway, she will go home and exercise that, exercise the do more and repeat, the nice feeling, the feeling, the feeling that she got from that experience." This theory is also concerned with the motivation behind the choices people make without any external influence and interference. An SFBT practitioner can therefore position themselves outside of a dominant pathologising discourse of problems because they are aware of the motivation within a person wanting to make changes (Chang & Nylund, 2013). This was apparent in this research because the difference between the approaches to trauma was demonstrated not only through the skills applied by practitioners, but also through a deeper understanding of what the client needed to gain a sense of relatedness to their perception of reality. "[...] what makes us different and that is our future, what makes us different is not the skills, it's not the miracle question, it isn't any of that, it is the philosophy that makes us different, because as long as I am here and, and the CBT Therapist is there he's going across that positivist line and I will be going along the constructionist line and it's the philosophies that will never change".

It is widely accepted that SFBT is considered to be an alternative to the problem focused approaches that seem to have triumphed in mental health clinical practice (Lewis & Osborn,

2004). SFBT was created as a reaction to the problem resolving model adopted by therapists at the Mental Research Institute (MRI) in California; the incentive of SFBT came from disillusionment with trying to understand the existence of problem (Lewis & Osborn, 2004). A non-pathological competency based approach to dealing with people was appealing to practitioners wanting more and was described by Prochaska and Norcross (1999) as "refreshing". SFBT holds the view that life can be complex and trying to find the 'causal aetiology' of problems can be ineffective leading to the potential narrowing of possible solutions, undermining self-efficacy, motivation and resilience (Cavanagh, 2006; Cavanagh & Grant, 2010; McKergow & Jackson, 2005; McKergow & Stellamans, 2011). In this study it was apparent that the practitioners had a huge amount of respect for the clients they were working with and were able to fully appreciate the levels of resilience the client had before entering therapy, which was not necessarily something that was going to evolve from therapeutic endeavour.

Problem focused thinking which can result in unhelpful rumination, with a persistent cognitive focus on problems (Nolen-Hoeksema & Morrow, 1991; Trapnell & Campbell, 1999), has been eschewed by SFBT practitioners. The problem focus is very apparent in the Diagnostic and Statistical Manual of Mental Disorders where it is argued that examples of a socially constructed reality influence practitioners' to make the mistake of thinking of it as an objective representation of reality (Guterman & Rudes, 2008). This argument was reflected in the practitioners' view of the definition of trauma where it seemed that they did not ground their understanding of what trauma might be in the DSM criteria and did not hold a concrete version of what it should look like in their minds. To challenge the misuse of the trauma label a solution focused thinking style is in contrast associated with well-being and positive affect because encouraging a person to think about the goals they want to achieve and how to attain those goals can stimulate pathways in the brain (Snyder, Rand & Sigmon, 2002), which

facilities avoidance of becoming too entrenched in a problem focused mind-set. Practitioners in this study encouraged clients to connect with the belief that life goes on, "Why is it, well because, because that really enables them to really see life really is happening anyway, beyond, or away from the problem, they are doing already, they are doing very good." Taking an active role in developing solutions where the practitioner can help the client in their pursuit of personally valued goals will have a positive effect on levels of self-efficacy, resilience and psychological flexibility (Beasley, Thompson & Davidson, 2003; Kashdan & Rottenberg, 2010; Peterson, 2006).

1.6.4 Moving on from trauma in SFBT

Despite experiencing trauma not every individual will develop symptoms associated with PTSD (Foa, Ehlers, Clark, Tolin & Orsillo, 1999) and various definitions of trauma have attempted to capture the important aspects that might help to separate trauma pathology from the normal challenges experienced in life that will not result in significant maladaptation (Spermon, et al., 2010). All of the practitioners could reflect on times when they had noticed post traumatic growth occur and one of the practitioners used a powerful analogy that seemed to capture what it meant to them, "what we are suggesting is well you fall off your bike, you pick yourself back up, you get back on the bike, you have grown, that's post traumatic growth." Most importantly post traumatic growth is thought to arise from the rebuilding of shattered assumptions about the self and the world, which as we will see later in the discussion is something that the SFBT practitioner facilitates as outlined by Visser (2012). One of the assumptions that seemed to be challenged by a practitioner is that trauma will be present in every aspect of the client's life, thus influencing their entire existence in the world. It was important for practitioners' to normalise the process whilst trying to contain it. "You know in the early days of working with trauma that's what, that's what you need to promote

you know the fact that yes in life we have trauma, but the possibilities are there because we do move on, we do have days when we forget."

Self-esteem and optimism are recognised to be correlates of growth nurtured by the solution focused practitioner who has confidence in the client's own ability to make positive changes to their life, by accessing their inner strength and resources (Lewis & Osborn, 2004). An example of this was illustrated by a practitioner who talked about the disabling effect of depression stemming from trauma; preventing a client from even noticing the smallest of positive changes they had made to their life on a conscious or unconscious level. There was even recognition of the power of the mind over a client's ability to see themselves in a different light. Furthermore, post traumatic growth requires effort in trying to look at new ways of positively reframing the situation and those who have experienced post traumatic growth will have been involved in a process of reappraisal coping (Ehlers & Clark, 2000; Hembree & Foa, 2004). This is actively encouraged in SFBT because of the postmodern philosophy which argues for the existence of multiple, intangible social realities (Gergen, 1991). Walter and Peller (1992) argued that the SFBT practitioner believes in the co-construction of multiple "possibilities" rather than focusing on one reality, enabling client to co-construct different ways of perceiving the traumatic event. These ideas about reality were shared by the practitioners in this study, which influenced how they were able to work with clients to try and develop their sense of a world that would not always involve trauma, emphasising that use of language was pivotal in this process.

The ability of a person to form healthy interpersonal relationships was also seen as a factor that could help them to overcome trauma (Schottenbauer et al., 2008), which would suggest that the quality of the therapeutic relationship between practitioner and client is one where growth can occur and is something that the SFBT practitioner is very much aware of. All of

the factors that are consistent with a humanistic approach to therapy are similar to those that are considered to be important to a SFBT practitioner, like; therapeutic collaboration, holding a non-judgemental attitude and having an engaging use of language where respect is shown for client experience (Lewis & Osborn, 2004). Some of the practitioners in this study had started their training in humanistic therapy and were passionate about the fundamental values that would constitute a therapeutic relationship. "I began with a diploma in person centred and I think that is, I mean that's core to most therapies really isn't it, that's the relationship, the empathy, the positive unconditional regard, the non-judgemental stance that you take as a therapist and that's still very much the case with solution focused but I suppose for that […] it almost relies on you, you, it being enough." The significance of the therapeutic relationship is integral to most psychological therapies and in SFBT once this was established clients were more receptive to challenging their own assumptions about trauma. This is especially important because it is understood that people who can form secure attachments are able to shield the aftermath of trauma displaying fewer PTSD symptoms (Mikulincer, Horesh, Eilati & Kotler, 1999). The practitioners referred to the difference in approaches where becoming focused on finding the "truth" gave clients the impression that the agenda for therapy is to fix the problem, whereas in SFBT the challenge comes in trying to encourage the client to realise there was never a problem in the first place because it was their perception that was causing the problem.

It is recognised that some clients might resist the SFBT approach because they might feel it does not fit their situation appropriately (Visser, 2012). However, as suggested by Lewis and Osborn (2004) resistance in the therapeutic relationship is affected by the interpersonal interactions between the client and the practitioner and is something that is not viewed exclusively within the client, but is instead a relational phenomenon that exists between interactions involving the practitioners in various settings. One of the practitioners were

perhaps aware of the resistance that could be present in the interview relationship because of the false nature of the process, "now I try, I work very differently and I work in an ethos of solution focused approach rather than just demonstrating the skills you see [...] even now as we speak in this, in this particularly formal setting, I would be demonstrating curiosity, hope". It is also argued that giving resistance a convenient label by a practitioner is often when an impasse has been reached and will undoubtedly prevent the exploration of solutions and working with the client collaboratively (Lewis & Osborn, 2004). Practitioners argued that some adult clients were resistant because they had closed their minds to the possibilities that lay before them, "It's easier with children, because they get it. They don't become obstructive and won't say "well what do you mean" or I can't imagine that when you're doing the miracle question for example. With adults you have to go back and revisit the miracle question with them sometimes because the first time they just get completely stuck like it's impossible." One way to overcome resistance would be that instead of offering advice based on experience and scientific evidence, solution focused change assumes that clients will benefit from identifying solutions within their own experiences (Anderson & Goolishian, 1992; Norum, 2000). Visser (2012) suggested that taking resistance into consideration can be productive because it can encourage the practitioner to be more cooperative leading to a deeper level of appreciation where therapeutic work is conducted within the clients frame of reference, resulting in a more refined and constructive approach. It seemed that practitioners in this study paid homage to clients because they recognised that with a little help from a SFBT perspective clients are encouraged to take stock of the things they have to help them overcome an experience of trauma, "faith in the ability of a person to kind of cure themselves really, they can do something about their situation themselves, they have got the resources within themselves and within the wider networks of family, friends etc."

1.6.5 IMPLICATIONS/RECOMMENDATIONS FOR RESEARCH AND PRACTICE

The study has helped to demonstrate that SFBT key factors that solution focused practitioners implement can help a client to foster resilience leading to post traumatic growth. With consideration given to future research it is necessary to have a way of measuring or benchmarking post traumatic growth, so that we are more aware of what it constitutes. Vicarious growth is something to also be mindful of because practitioners may have experienced growth during therapy in addition to the clients; linked to length of time practising, where growth on a personal level was discussed by more experienced practitioners. There are other research questions that can be explored through future SFBT research, for example; different types of growth might occur for clients and how they manifest could be explored, or how different traumas might react differentially in treatment. Also finding out if SFBT is more effective with specific trauma, and identification of the essential components which can facilitate growth within an experimental design, would inform the NICE guidelines.

In the study it was noticed how very little attention is given to "trauma" as a label; the use of language can lead to a positive change in perception if there is less of an emphasis on the existence of problems; all relative to the subjective nature of reality. The findings imply that SFBT might only be effective if utilised by practitioners with some experience of another therapeutic orientation, because SFBT is almost understood as catalyst for growth on a personal and professional level, which the practitioner goes through in order to reach actualisation. It also became apparent that more experienced practitioners were at ease with the use of SFBT techniques and felt comfortable applying these to any client issue. However, practitioners with less experience at times felt out of their depth, questioning whether the approach would be effective for specific issues, like trauma. It is therefore recommended that

practitioners interested in this approach consider their level of experience before trying to work from an SFBT orientation; the approach requires an understanding and acceptance of the philosophical underpinnings of SFBT made sense of with prior experience of therapy and possibly through active involvement with different therapeutic approaches. All practitioners once immersed in the approach became solution focused in their way of being because of the influence of a social constructionist philosophy, which can prove challenging because of societal influences on how problems should be perceived.

SFBT offers brief therapy to clients and as highlighted by Gingerich and Peterson, (2012) there are economic implications for funders and policy makers where it is suggested that clients can achieve their goals sooner and move on with their lives. Bor, Gill, Miller and Parrott (2004) discussed the misconceptions around offering 'more therapy' which is perceived as being somewhat better than brief therapy, which is also not short term therapy (Hoyt, 1995), but is long term therapy condensed into less time (Bor et al., 2004). It was argued by Bor et al., (2004) that it takes some skill on behalf of the practitioner to challenge the perspective of psychological problems, brief therapy is categorically not about 'papering over' problems, ignoring the events that caused the problem, or about avoidance of the expression of feeling; being distressed does not mean that the client is incompetent. Hence why the practitioners in this study argued that SFBT could be the therapeutic approach that would serve as the saving grace for the shortcomings of other therapies proving too costly, "if they have economic pressure put on them I think solution focused can save their bacon, that's what they are calling for." There is much anecdotal evidence to support this claim and it is important to acknowledge that some clients prefer the practical, time limited, strengths based approach that it provides, and most importantly continued efforts need to be made to enable clients to have a voice in their preference for an intervention approach (Gingerich & Peterson, 2012). It is argued that there is a place for SFBT in the field of counselling

psychology mainly due to the strengths it has in being brief by nature, which is now favoured over long term therapy due to financial implications influencing how many sessions are offered to clients, and it is also recommended that working in a social constructionist way would in fact compliment the values and practices already fundamental to the counselling psychologist (Lyddon, 1998), further highlighted in this discussion.

Within those interviewed, there was some reluctance to work in an integrative way through fear of perhaps diluting the approach. However, what needs to be taken into consideration is that there are now four hundred models of psychotherapy now available (Corsini & Wedding, 2000; Prochaska & Norcross, 1999), so it has become a rather competitive field where various therapeutic approaches have to fight for attention. Practitioners in this study reflected on their own application of the approach and how at times settings dictated the way in which they worked with clients due to the fact that measurable outcomes are favoured, "I think CBT has got a bigger mouth, seems to be getting better results, seems to be doing this, seems to, well have you noticed I use a lot of seems." As argued by Guterman (1996) it is clear that there will undoubtedly be factors across all of the therapies that contribute to positive outcomes and emphasis will need to be put on these rather than trying to isolate the unique contributions of a particular approach; SFBT if it is to survive in the current culture may need to be promoted as an adaptable and compatible with other approaches. Furthermore, if SFBT is to be embraced by the current culture it will need to demonstrate that it is moving with the times and practitioners' in this study seemed to suggest that it might have become a little stagnant due to the lack of development in the practical ways in which it can work, "there are new ways of actually working with SFBT rather than just spoon feeding it [...] they talk about you know the sort of bits of the model that everyone is familiar with now, like the miracle questions, and I am quite interested in developing other ways of actually working with people."

1.6.6 CRITIQUE OF THE PRESENT STUDY

The present study explored the experiences of practitioners facilitating SFBT from one established centre. It is acknowledged that this particular context can frame the responses of the participants, because within that culture there are internal dynamics and politics not perhaps overtly obvious, which may influence subjective responses to interview questions. Inherent internal politics and particular ways of working fundamental to the centre may play out in the findings, making generalizability more difficult. However, this was not the aim of this study. A contextual factor that may have been overlooked is the client base that the centre attracts. It is based in a city centre location and clients will undoubtedly be exposed to different traumas in comparison to a rural location. If the location of the setting had been situated in an area where terrorism takes place regularly or in an occupational setting, such as the armed forces, then different findings would have emerged and is something that can be considered for further research. However, it was of value to collect data from one centre because the researcher could verify credibility of the setting; limit the potential biases from different institutions, which may have led to misleading findings; and keeping the context consistent helped the researcher to select the particular focus of the study. It would be informative to explore whether consistent findings emerged from another centre offering SFBT, because further discussions are centred on potential differences between ways of working in different centres. The clients who have received SFBT in order to overcome trauma were not included in this study because the aim was to explore the practitioners' perspective. This in itself is interesting because we learn more about how SFBT can be integrated with other approaches when working with trauma, and how it can be applied in a purist fashion because the underpinning philosophy makes it different to approaches from a positivist position, for example.

The trustworthiness of the findings might be brought into question because it would be difficult to generalise due to the subjectivity involved during interpretation. However, due to the use of qualitative methods of analysis, generalizability was not considered as a major concern. It is understood that a framework for ensuring the trustworthiness of qualitative research is essential, hence why the paper published by Shenton (2004) was used to inform the key research decisions safeguarding against issues that would bring the trustworthiness of this study into question. This paper was selected because of the focus on the constructs founded by Guba; a naturalistic investigator who used terminology detached from a positivist paradigm (Shenton, 2004). Guba (1981) outlined four criteria for trustworthy qualitative research corresponding to the criteria that is adhered to by a positivist researcher: credibility (in preference to internal validity); transferability (in preference to external validity/generalizability); dependability (in preference to reliability); confirmability (in preference to objectivity), and as shown in the method section each provision was employed by the researcher to ensure they were met.

During the analysis part of the research there was the possibility of researcher bias. As an SFBT Practitioner even though efforts were made to guard against this, the methodology chosen allowed for the researchers own perspective to be an inherent part of the process. Equally only six participants were interviewed, which makes the sample very small considering how many people might draw upon the principles of SFBT in their working practice, but interviewing only six practitioners allowed for an in-depth exploration of their experiences.

1.6.7 CONCLUSION

This study aimed to look at the way in which SFBT is effective for trauma work because it can help clients come to terms with such an experience. It was acknowledged at the start of

this paper that SFBT is effective because it promotes post traumatic growth (Bannink, 2008). Prior to undertaking the study it was unclear what SFBT could do to foster post traumatic growth in clients, and it was understood that in order to learn more about the mechanisms of SFBT the practitioners working with this approach needed to be asked. The research question for this study is as follows:

"What are the experiences of solution focused practitioners' in the facilitation of post-traumatic growth during brief therapy?"

This study has addressed the research question because it has provided insight into the role of the SFBT practitioner facilitating post traumatic growth during brief therapy. The use of IPA has enabled the researcher to get a true sense of the SFBT practitioner during their experiences of facilitating post traumatic growth, which would have been missed if the researcher had decided to approach the research from a quantitative perspective. This study has helped the reader to at least acknowledge that SFBT can help clients to overcome trauma and has also highlighted the need for further research in order to gain a better understanding of what it is about the approach specifically, for example the use of solution focused techniques, that would help a client to overcome trauma, particularly in relation to other approaches where outcome based measures are already being utilised. This research has highlighted the significance of this approach in the trauma field in that it is suitable for clients who do not want to dwell on their trauma experience(s) or dissect the trauma in order to try and reprocess it, because they would simply prefer to move on with their lives by building on the resilience they already have.

Most importantly the research has helped to highlight the significance of the SFBT practitioner who despite being surrounded by political and social issues which might try to influence or dictate how trauma should be treated, are still able to be true to themselves

because of their personal values and loyalty to the approach. They are reluctant to try and integrate it with other approaches; fundamentally because the underlying philosophical principles are very different to that of CBT for example.

1.7 CRITICAL REVIEW

This section will consist of a critical appraisal on the empirical study where the process that was undertaken will be explored and critiqued in relation to how the research ideas evolved, how the research was conducted and the reflections that were observed throughout the duration of the research process. This research was conducted because there were some personal aims I wanted to achieve. *Firstly,* after learning about SFBT I wanted to build on my knowledge by learning more about the application of it and how it might help clients who have experienced trauma, *secondly,* I wanted to contribute to the research literature because I became aware of the gap where SFBT as an approach is not considered to be a psychological intervention that can help with trauma experiences, *thirdly,* I am aware of the misconceptions held by some of my peers about SFBT and this encouraged me to learn more about the approach from the practitioners themselves, to try and gain an honest insight into its effectiveness in practice.

Whilst trying to formulate ideas about the type of research I wanted to conduct, consideration was given to developing the research conducted for my Masters in Counselling Psychology. For this research I looked at the crisis intervention experiences of practitioners' at risk of vicarious traumatisation. All of the participants were recruited from the same establishment because we formed part of the Psychology Crisis Service in a female prison. The research had personal significance for me because I was also part of the Crisis Service and recognised that as professionals we were exposed to risks that had the potential to negatively impact upon our wellbeing. From the results I found that practitioners were at risk when they did not utilise supervision and personal therapy effectively. Conducting research in this setting proved difficult, due to several obstacles encountered, for example: trying to recruit suitable participants, and needing to gain authorisation from the governor. Personal development

came from reflection raising awareness of the organisational hierarchy emphasising a power and control divide, giving prisoners the impression that psychology were the 'experts' and would be able to rescue them from their distress.

As a result of this early experience in my career I wanted to look at the influence of systems and how individuals fit into them. I was inspired to take practical action, so part way through my Doctorate I completed a course on SFBT. Working from a social constructionist standpoint helped me to think about the use of language and how when we engage in conversations with people problems can be generated and embedded in patterns of communication, rather than stemming from within the individual or externally (O'Connell, Palmer & Williams, 2012). Having this awareness made me question the use of labels, especially when clients with experiences of trauma are perceived as, "damaged" in some way. This led me to wonder about how much of an influence perception can have upon clients trying to move on from their experiences, when professionals are almost suggesting their identity is the label imposed on them. Whilst looking at research that had already been conducted on the topic of trauma, previous studies guided my decision making and due to being familiar with SFBT marrying the two together seemed like a constructive way forward. As I am very much interested in the mechanics of SFBT and how it could facilitate growth in a client, I wanted to explore what this could mean for practice.

My desire to study and research SFBT further challenged my role in therapy by the questions I posed regarding what clients needed from me in order to move on. As a result I sought advice from my research supervisor and mutually it was agreed that ideas I had about wanting to conduct research on SFBT needed to be anchored to the facilitation of post-traumatic growth. I was directed to the work of Joseph and Linley (2006), who argued that a

traumatic event can act as a catalyst for personal growth and positive change and they recommended that more attention needed to be paid to the facilitation of growth through therapy (Linley & Joseph, 2004). With their findings in mind my research question evolved into looking at the experiences of the solution focused practitioners' facilitating post traumatic growth during brief therapy, because it was recognised that this approach had not really been considered in the field of trauma therapy previously, simply because other approaches like: EMDR, were more established and had an evidence base. Furthermore, it was decided that in order to analyse the practitioners' experiences in depth Interpretative Phenomenological Analysis (IPA) was employed because it was the method of analysis that by comparison to other forms of analysis fitted how I wanted to look at the data obtained. Being familiar with this approach, having used it for a previous Masters project, instilled me with confidence about its application allowing for interpretations to be made from the experiences of the research participants.

To recruit suitable research participants an organisation that worked from the solution focused approach in a purist way was approached. There are only two centres to my knowledge in the United Kingdom that use SFBT specifically in their client work. This validated my decision to conduct research in this area, because the profile of SFBT was going to be raised. When analysing the interviews I immersed myself in the interview material and followed guidance recommended by Smith et al., (2009), where each participant account was analysed in isolation from the other. I was also aware of the potential to influence what had been said by each participant because I was overly keen to help them to have a voice through the interview. My research journal was used to prevent this from happening because it felt important to be objective when looking at each interview, because I did not want the data to merge into each other. The process was very demanding because it required a lot of effort and attention; at times it was also a little draining because I was conscious of remaining objective

at all times. I regularly discussed the process of analysis with my research supervisors where they helped me to remain objective encouraging the sharing of my thoughts and opinions. They also read though the findings to see if they were in relation to the overall aim of the research. The themes emerged from the data and it felt like they were leaping out from the page where most of the participants had shared similar experiences of SFBT, especially in their view of the problem world where clients had become consumed by their problems – a lot of them talked about social constructionism and how this philosophical standpoint had influenced their decision to engage with SFBT and also their perception of trauma where some of them struggled to identify with the label at all. Some of the participants engaged with SFBT because it was more practical and less time consuming helping the practitioners to move clients on in three sessions or less. I wondered if this was something to do with the male participants' because it was recognised that some of them wanted to help the client to take action. However, this was an assumption and it was soon realised that it was not just associated with male participants, but was also something that the female participants' could relate to. The effectiveness of the approach seemed very important in relation to the expectations in today's society where people want quick results and the approach seems favourable because it is more affordable for clients who cannot engage with long term therapy.

Due to the fact the research is looking at trauma and post-traumatic growth in relation to the application of SFBT, it is important to refer to the theoretical standpoints and how this might affect the practitioners' notion of trauma and the phenomenon that is post traumatic growth. Conducting this research has enabled me to reflect on my perception of trauma because prior to my involvement with this I thought that trauma was an abstract concept that could only alter a person's view of reality in a negative way. I also believed that the experience of trauma had the potential to cause further mental health implications and that therapy by all

accounts might not be effective for the most horrific experiences. It is fair to say that my assumptions were challenged by the practitioners I interviewed. All of them had backgrounds in either counselling and or psychology and it was interesting to reflect on why they had moved from their initial theoretical orientation to SFBT in order to search for new meaning in their lives. In therapy they held a position of power because they are able to challenge the perception of trauma and what it means to an individual who has experienced this and survived as a result. Having the opportunity to challenge the meaning of trauma in therapy has implications for working practice because we can question the decisions made by service providers when they make recommendations about clients who have experienced trauma and the type of intervention they should receive. Trying to enforce an expert view on someone who has experienced something which has tested them beyond imagination seems unethical and disrespectful.

Staying true to the values of a counselling psychologist and the social constructionist underpinnings of SFBT will enable me to take a proactive role in ethical decision making for the benefit of our clients. Reflexivity has helped me to do this and as argued by Banister, Bruman, Parker, Taylor and Tindall (1994) reflexivity in all its pretexts is an integral part of qualitative research. Throughout the research process I kept a personal journal which helped me to reflect and take ownership of my perspective (Elliot, Fischer & Rennie, 1999). At the time of analysis I had to make a conscious effort to remain positive about personal changes that occurred within my personal life and because I was committed to ongoing reflection I ensured that my research was protected from this and remained valid, this as recommended by Stiles (1999) is good practice. I was very aware of the potential impact of these issues which could have affected my ability to interpret the results objectively and believed that applying SFBT to my personal life complimented my role as a researcher. I noticed how I found analysis of the descriptive comments easier than the interpretative and this might have

been due to a fear of not being accurate or by trying to read too much into a point than was necessary. My awareness of the importance of the hermeneutic part of the research where in IPA I can make a commitment to exploring the 'life-world' of each participant and make sense of their experiences (Gee, 2011) was integral to my role as a researcher. I became involved in the research and the concept of 'inter subjectivity' is integral to this; in phenomenology psychological research crucial elements are that we are able to communicate with each other and understand each other (Gee, 2011). It was imperative that I understood my participants, how I was making sense of their experiences and the process I was going through when immersed in the data to understand what happening; all of which were discussed in supervision and recorded in the research journal.

As I conclude this section it is important to recognise how much growth has taken place on a professional and personal level. When working with clients I am now able to see them as survivors rather than victims because they have the inner resources and resilience to keep going even in the face of adversity. Furthermore, although I adhere to NICE guidelines to inform my practice I also draw on my experience of what works with clients and recognise that applying SFBT can be very powerful in the therapeutic arena. I have learned a few things that have influenced my development as a scientist-practitioner and how to conduct research that is 'trustworthy' by using the guidelines recommended by Shenton (2004). I am very passionate about my research and wanted to act as an advocate for SFBT; in the wider context of psychological therapies being offered for trauma this approach has not been recognised. As an individual I am aware that I cannot take on established systems with their internal politics and dynamics, so I have learned to be more objective by emphasising the power of this approach through the research, allowing it to speak for itself. I have become familiar with various articles concerning research on trauma and post-traumatic growth and these findings have provided me with a sound foundation on which I hope to build my

argument for further research in this field. I am aware of my development as a scientist-practitioner because I have learned how to write in an academic way; this growth has certainly been nurtured through submitting a draft thesis to my supervisors where I was encouraged to hone the skills acquired. Trying to capture the essence of the research through my writing has been challenging, but keeping the aims and objectives in mind has certainly helped me to focus on what I want to achieve.

1.7.1 CONTRIBUTION TO THE FIELD OF COUNSELLING PSYCHOLOGY

Conducting this research has promoted the application of SFBT in the facilitation of post-traumatic growth because it is a practical approach that can help individuals to move forward. Furthermore, the accounts given by the practitioners were inspiring because they shared aspects of their life journey and what had helped them to come to terms with their own traumas/problems. It is assumed that critics will question how effective SFBT can be in the field of trauma work and it is hoped that the research will encourage others to build on the findings, perhaps through a quantitative study where the specific techniques employed by the practitioners can be identified and evaluated to see how effective they are when working with trauma. Conducting research from a qualitative perceptive helped me to uncover some of the mystery surrounding the role of the solution focused practitioner, because until now we have known very little about what it is that they do in the realms of an SFBT framework. For the future it would be interesting to see how SFBT might be able to work with other client groups, like; couples, or different cultures – sometimes the more established approaches might fail to take into consideration how different cultures operate in their own systems. This is something SFBT is conscious of because of its recognition of the existence of multiple and intangible social realities (Gergen 1991).

Furthermore, the study could not have gone ahead if it was not for the participants who agreed to take part and I am thankful they allowed me to enter into their worlds and see their experiences though their eyes, because in doing so it has taught me to challenge my own beliefs and assumptions.

1.7.2 CONCLUSION

This research has evolved from recognition of my ability to relate to SFBT on a personal level, it has helped me to overcome experiences of trauma leading to personal growth. As a scientist-practitioner I am confident this study will be the catalyst for additional research in this area, either through my passion to make further contributions, or by inspiring others to build upon the work already conducted.

2. REFERENCES

REFERENCES

Allen, J. G. (1995) *Coping with trauma: A guide to self-understanding*. Arlington, VA. US: American Psychiatric Association.

American Psychological Association (2000) *Diagnostic and statistical manual of mental disorders.* (4th ed.) Washington. DC: Author

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.) Washington, DC: Author

Anderson, H. & Goolishian, H. (1991) Thinking about multi-agency work with substance abusers and their families: A language systems approach. *Journal of Strategic and Systemic Therapies,* 10, 20-35.

Antonovsky, A. (1987) *Unravelling the mystery of health. How people manage stress and stay well*. Jossey-Bass Inc Publishers, San Francisco, London.

Banister, P., Bruman. E., Parker, I., Taylor, M., & Tindall, C. (Eds.) (1994). *Qualitative methods in psychology: A research guide*. Buckingham, Open University.

Bannink, F. P. (2008) Posttraumatic success: Solution-focused brief therapy. *Brief Treatment and Crisis Intervention*. 8(8), 215-225.

Barbour, R. (2007) *Introducing qualitative research: A student guide to the craft of doing qualitative research*. SAGE Publications. London.

Baudrillard, J. (1988) The Masses: The Implosion of the social in media. In M. Poster (Ed). *Baudrillard: selected writings*. Stanford, Stanford University Press. 210-223.

Beasley, M., Thompson, T., & Davidson, J. (2003) Resilience in response to life stress: the effects of coping style and cognitive hardiness. *Personality and Individual Differences.* 34, 77-95.

Beck, A. T. (1975) *Cognitive therapy and emotional disorders*. New York: Meridan.

Becker, C., Zayfert, C., & Anderson, E. (2004) A survey of psychologists' attitudes and utilisation of exposure therapy for PTSD. *Psychology Faculty Research*. 7, 1-32.

Berg, I. K. (1994) *Family-based services: A solution-focused approach*. New York: Norton.

Berg, I. K. (1995) Solution focused brief therapy with substance abusers. In A. M Washton (Ed.) *Psychotherapy and substance abuse: A practitioner's handbook*. New York: Guilford Press. 223-242.

Berg, I. K., & De Jong, P. (1996) Solution-building conversations: Co-constructing a sense of competence with clients. *Families in Society: The Journal of Contemporary Human Services.* 376-391.

Berg, I. K., & Dolan, Y. (2002) Tales of solutions: A collection of hope-inspiring stories. New York: Norton.

Beyebach, M. (2000) *European brief therapy association outcome study: Research definition.* Retrieved from http://www.solutionsdoc.co.uk/ebtamain

Bonanno, G. A. (2005) Loss, trauma and human resilience. *American Psychologist*. 59(1): 20-28

Bonanno, G. A., Rennicke, C., & Dekel, S (2005) Self-enhancement among high exposure survivors of the September 11th terrorist attack: Resilience or social maladjustment? *Journal of Personality and Social Psychology*. 8(6): 984-998.

Bor., R., Gill, S., Miller, R., & Parrott, C. (2004) *Doing Therapy Briefly*. Palgrave Macmillan.

Bradley, R., Greene, J., Russ, R., Dutra, L., & Westen, D. (2005) A multidimensional meta-analysis of psychotherapy for PTSD. *The American Journal of Psychiatry*. 162(2), 214-227.

Braun, V., & Clarke. V. (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology*. 3(2), 77-101.

Briere, J. (2004) *Psychological assessment of adult posttraumatic states: Phenomenology, diagnosis and measurement.* (2nd ed). Washington. DC: American Psychological Association.

Bruner, J. (2004) The narrative creation of self. In L. E. Angus., & J. McLeod (Eds.). *The handbook of narrative and psychotherapy: practice, theory and research*. California: Sage.

Burwell, R. C., & Chen, C. P., (2006) Applying the principles and techniques of solution-focused therapy to career counselling. *Counselling Psychology Quarterly*. 19(2), 189-203.

Butler, G. (1998) Clinical formulation. *Comprehensive Psychology*. 6(1), 1-23

Byrd-Craven, J., Geary, D.C., Rose, A. J., & Ponzi, D. (2008) Co-ruminating increase stress hormone levels in women hormones and behaviour. *Hormones and Behavior.* 53(3), 489-492.

Cashdan, S (1988) *Object Relations Therapy. Using the Relationship*. New York: Norton.

Cavanagh, M. (2006) Coaching from a systemic perspective: A complex adaptive conversation. In D. Stober & A. M Grant (Eds) *Evidence Based Coaching Handbook.* 313-354. NJ: Wiley.

Cavanagh, M., & Grant, A. M. (2010) The Solution Focused Approach to Coaching. In E. Cox, T, Bachkirova & D. Cutterbuck (Eds) *Sage Handbook of Coaching.* 34-47. London: Sage.

Cerney, M. S. (1985) Countertransference Revisited. *Journal of Counselling & Development*, 63, 363-364.

Chang, J., & Nylund, D. (2013) Narrative and Solution-Focused Therapies: A twenty-year retrospective. *Journal of Systemic Therapies.* 32(2), 72-88.

Chevalier, A. J. (1995) *On the client's path: A manual for the practice of solution-focused therapy.* Oakland, CA: New Harbinger Publications.

Clark, D. M., & Ehlers, A. (2004) Posttraumatic stress disorder: from theory to therapy. In R. L. Leahy (Ed.) *Contemporary Cognitive Therapy*. 141-160. New York: Guilford.

Cockburn, J. T., Thomas, F. N., & Cockburn, O. J. (1997) Solution Focused Therapy and Psychosocial Adjustment to Orthopaedic Rehabilitation in a Work Hardening Program. *Journal of Occupational Rehabilitation*. 7(2), 97-106.

Conrad, P. (1987) The experiences of illness: recent and new directions. *Research in the Sociology of Health Care*. 6, 1-31.

Corcoran, J., & Pillai, V. (2007) A review of the research on solution focused therapy. *British Journal of Social Work*. 39: 234-242.

Corcoran, J., & Pillai, V. (2009) A review of the research on solution-focused therapy. British *Journal of Social Work.* 39, 234-242.

Corsini, R. J., & Wedding, D. (Eds) (2000) *Current Psychotherapies.* (6th ed.) Itasca, IL: Peacock.

Dallos, R., Stedmon., J., & Johnstone, L. (2014) Integrative formulation in theory. In L. Johnstone & R. Dallos (Eds) *Formulation in Psychology and Psychotherapy*.

Data Protection Act (1998) retrieved in January 2015 from: *http://www.legislation.gov.uk/ukpga/1998/29/contents*

Davidson, J. R. T., & Foa, E. B. (1993) Epilogue. In J. R. T Davidson & E. B Foa (Eds) *Post-traumatic Stress Disorder. DSM-IV and Beyond.* 229-235.

Deci, E.L., & Ryan, R. M. (2000) The "What" and "Why" of goal pursuits: Human needs and the self determination of behaviour. *Psychological Inquiry*. 11(4), 227-268.

De Jong, P., & Berg, I. K. (1997) *Interviewing for Solutions.* Pacific Grove: CA Brooks/Cole.

De Jong, P., & Berg, I. K. (1998) *Interviewing for Solutions*. Belmont. CA: Thompson Publishing.

Dermer, S., Hemesath, C., & Russell, C. (1998) A feminist critique of solution focused therapy. *American Journal of Family Therapy*. 26, 239-250.

Derrida (1997) *Of Grammatology*. Baltimore: The John Hopkins University Press.

De Shazer, S. (1984) The Death of Resistance. *Family Process.* 23: I, 1-17

De Shazer, S. (1985) *Keys to Solution in Brief Therapy*. New York: WW. Norton.

De Shazer (1988) *Clues: Investigating solutions in brief therapy.* New York: W. W. Norton.

De Shazer, S., & Berg, I. K. (1997) 'What Works?' Remarks on research aspects of solution-focused brief therapy. *Journal of Family Therapy*. 19(2), 121-124.

De Shazer, S., Berg, I. K., Lipchik, E., Nunnally, E., Molnar, A., Gingerich, W., Weiner-Davis, M. (1986) Brief therapy: Focused solution development. *Family Process*, 25 (2), 207-221.

De Shazer, S., Dolan, Y. M., Korman, H., Trepper, T. S., McCollum, E. E., & Berg, I. K. (2007) *More than miracles: the state of the art of solution focused therapy*. New York: Haworth Press.

Diamond, D. (2010) Psychodynamic contributions to pluralistic practice. In M. Milton (Eds) *Therapy and Beyond: Counselling Psychology Contributions to Therapeutic and Social Issues.* John Wiley & Sons Ltd.

Dolan, Y. (1991) *Resolving sexual abuse. Solution-focused therapy and Ericksonian hypnosis for adult survivors*. New York: Norton.

Dudley, R., & Kuyken, W., & Padesky, C. A. (2010) Disorder specific and trans-diagnostic case conceptualisation. *Clinical Psychology Review*. 31, 213-224.

Duncan, B., Solovey, A., & Rusk, G. (1992) *Changing the rules: A client-directed approach to therapy.* New York: Guilford.

Dunmore, E., Clark, D. M., & Ehlers, A. (1999) Cognitive factors involved in the onset and maintenance of posttraumatic stress disorder (PTSD) after physical or sexual assault. *Behavior Research and Therapy*. 37, 809-829.

Durrant, M. (1993) *Residential treatment: A cooperative competency based approach to therapy and program design*. New York: W. W. Norton.

Eckert, P. (1993) Acceleration of change: catalysts in brief therapy. *Clinical Psychology Review*. 13, 241-253.

Ehlers, A., & Clark, D. M. (2000) A cognitive model of posttraumatic stress disorder. *Behavior Research and Therapy*. 38, 319-345.

Ehlers, A., & Steil, R. (1995) Maintenance of intrusive memories in *posttraumatic stress disorder: A cognitive approach. Behavioural* and Cognitive Psychotherapy. 23, 217-249.

Eisner, E. W. (1991) *The enlightened eye: Qualitative Inquiry and the enhancement of educational practice*. New York. NY: Macmillan Publishing Company.

Elliott, R., Fischer, C.T. & Rennie, D.L. (1999). Evolving Guidelines from Publication of Qualitative Research Studies in Psychology and Related Fields. *British Journal of Clinical Psychology*. 38, 215-229

Fish, J. M. (1995) Does problem behaviour just happen? Does it matter? *Behavior and Social Issues.* 5(1), 3-12.

Fish, J. M. (1997) Paradox for complainants? Strategic thoughts about solution focused therapy. *Journal of Systemic Therapies*. 16(3), 266-273.

Fiske, H., & Zalter, B. (2005). A solution-focused group message. *Journal of Family Psychotherapy*, 16(1–2)

Fleeson, W. (2012) Perspective on the person: rapid growth and opportunities for integration. In K . Deaux & M. Snyder (Eds.). *The Oxford Handbook of Personality and Social Psychology*. 33-63. New York: Oxford University Press.

Foa, E. B., Ehlers, A., Clark, D. M., Tolin, D. F., & Orsillo, S. M. (1999) The Posttraumatic Cognitions Inventory (PTCI): Development and Validation. *Psychological Assessment*. 11(3), 303-314.

Foa, E. B., & Kozak, M. J. (1986) Emotional processing of fear: Exposure to corrective information. *Psychological Bulletin*. 99, 20-35.

Foa, E. B., & Riggs, D. S. (1993) Posttraumatic stress disorder in rape victims. In J. Oldham, M. B. Riba, & A, Tasman (Eds.) *Annual Review of Psychiatry*. 12, 273-303. Washington, DC, American Psychiatric Association.

Foa, E. B., & Rothbaum, B. O. (1998) *Treating the trauma of rape: A cognitive behavioural therapy for PTSD*. New York: Guilford.

Foa, E. B., Steketee, G., & Rothbaum, B. O. (1989) Behavioural/cognitive conceptualisations of post-traumatic stress disorder. *Behavior Therapy*. 20, 155-176.

Foa, E. B., Zinbarg, R., & Rothbaum, B. O. (1992) Uncontrollability and unpredictability in posttraumatic stress disorder: an animal model. *Psychological Bulletin*. 112, 218-238.

Franklin, C. (1998) Distinction between social constructionism: therapies, practice, practice applications. In C. Franklin., & P. Nurius (Eds.) *Constructivism in practice: methods and challenges.* 57-94. Milwaukee. WI: Families International.

Frank, E., & Stewart, B. D. (1983) physical aggression: treating the victim. In E. A Bleckman (Ed) *Behavior Modification with Women*. 245-272. New York: Guilford Press.

Frank, E., & Stewart, B. D. (1984) Depressive symptoms in rape victims. *Journal of Affective Disorders.* 1, 269-277.

Gee, P. (2011) 'Approach and Sensibility': A personal reflection on analysis and writing using Interpretative Phenomenological Analysis. *Qualitative Methods in Psychology Bulletin,* 11.

Geltner, P (2006) The concept of object countertransference and its role in a two person psychology. *The American Journal of Psychoanalysis*. 66, 25-42.

Gergen, K. J. (1985) The social constructionist movement in modern psychology. *American Psychologist,* 40, 266-275.

Gergen, K. J. (1991) *The saturated self: Dilemmas of identity in contemporary life*. New York: Basic Books.

Gergen, K. J. (1997). The place of the psyche in a constructed world. *Theory & Psychology,* 7, 723–746

Gergen, K. J., & Gergen, M. (2004). *Social construction: Entering the dialogue*. Chagrin Falls, OH: Taos Institute.

Gingerich, W. J., & Eisengart, S. (2000) Solution focused brief therapy: A review of the outcome research. *Family Process*. 39, 477-498.

Gingerich, W. J., & Peterson, L.T. (2012). Effectiveness of Solution Focused Brief Therapy: A Systematic Qualitative Review of Controlled Outcome Studies. *Research on Social Work Practice,* DOI: 10.1177/1049731512470859. Retrieved in February 2015 from: http://rsw.sagepub.com/content/early/2013/01/22/1049731512470859.abstract

Gingerich, W. J., & Peterson, L. T. (2013) Effectiveness of solution focused brief therapy: A systematic qualitative review for controlled outcome studies. *Research on Social Work Practice*. 23(3), 266-283.

Giorgi, A. (2000) Concerning the application of phenomenology to caring research. *Scandinavian Journal of Caring Sciences*. 14(1), 11-15.

Glaser, B. G., & Strauss, A. L. (1967) *The discovery of grounded theory: strategies for qualitative research.* Chicago, Aldine Publishing Company.

Golafshania, N. (2003) Understanding reliability and validity in qualitative research. *The Qualitative Report.* 8(4), 597-606.

Gonzalez-Prendes, A., & Resko, S. M. (2012) Cognitive Behavioural Theory. In S. Ringel., & J. Brandell (Eds.). *Trauma: contemporary directions in theory, practice and research.* SAGE Publications Inc.

Grant, A. M., Cavanagh, M. J., Kleitman, S., Spence, G., Lakota, M., & Yu, N. (2012) Development and validation of the solution focused inventory. *The Journal of Positive Psychology*. 7 (4): 334-348.

Greene, G. J., Lee, M. Y., Trask, R., & Rheinscheld, J. (2005). How to work with clients' strengths in crisis intervention: A solution-focused approach. In A. R. Roberts (Ed.), *Crisis intervention handbook: Assessment, treatment, and research* (3rd ed.). (pp. 64–89). New York: Oxford University Press

Gruen, R. J., Folkman, S., & Lazarus, R. S. (1988) Centrality and individual differences in the meaning of daily hassles. *Journal of Personality.* 56(4), 743-762.

Guba, E. G. (1981) Criteria for assessing the trustworthiness of naturalistic inquiries. *Educational Communication and Technology Journal*. 29, 75-91.

Guterman, J. T. (1996) Doing mental health counselling: A social constructionist revision. *Journal of Mental Health Counselling*. 18, 228-252.

Guterman, J. T., & Rudes, J. (2008) Social Constructionism and ethics. *Implications for counselling.* 52(2), 136-144.

Hagen, B. F., & Mitchell, D. L. (2001) Might within the madness: solution focused therapy and thought disordered clients. *Archives of Psychiatric Nursing*. 15(2), 86-93.

Hansen, J. T. (2005) The devaluation of inner subjective experiences by the counselling profession: A plea to reclaim the essence of the profession. *Journal of Counseling and Development.* 83, 406-415.

Hawkes, D., March, T., & Wilgosh, R. (1998) *Solution-focused therapy: A handbook for health care professionals*. Oxford: Butterworth-Heinemann.

Health and Care Professions Council (2012) *Standards of conduct, performance and ethics.* Retrieved in November 2014 from: http://www.hpcuk.org/aboutregistration/standards/standardsofconductperformanceandethics/

Heidegger, M. (1975) *Poetry, Language, Thought*. Harper & Row Publishers.

Hembree, E. A., & Foa, E. B. (2004) Promoting cognitive change in posttraumatic stress disorder. In M. A. Reinecke., & D. A. Clark (Eds.) *Cognitive therapy across the lifespan: evidence and practice*. 231-257. New York: Cambridge University Press.

Herman, J. L. (1992) Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *Journal of Traumatic Stress*. 5, 377-391.

Holmes, J. (1994) Brief Dynamic Psychotherapy. *Advances in Psychiatric Treatment*. 1, 9-15

Horowitz, M. J. (1997) *Stress response syndromes. PTSD, Grief and Adjustment Disorders*. Northvale, NJ: Jason Aroson.

Hox, J. (2002) *Multilevel analysis techniques and applications.* Mahwah, NJ: Lawrence Erlbaum.

Hoyt, M. F. (1995) *Brief Therapy and Managed Care: Readings for Contemporary Practice*. San Francisco: Jossey-Bass.

Hudson, P. O., & O'Hanlon, W. H. (1991) *Rewriting love stories: Brief marital therapy*. New York: W. W. Norton.

Jayawickreme, E., & Blackie, L. E. R. (2014) Post-traumatic growth as positive personality change: Evidence, controversies and future directions. *European Journal of Personality*. 28, 312-331.

Jaycox, L. H., Zoellner, L., & Foa, E. B. (2002) Cognitive-Behavior therapy for PTSD in rape survivors. *Journal of Clinical Psychology*. 58(8), 891-906.

Jeffrey, C. V. M., Guterman, J. T., & Shatz, K. (2012) *Solution Focused Counselling for eating disorders.* Retrieved in September 2014 from http://www.counseling.org/library/

Johnson, S. M., & Greenberg, L. S. (1985) The differential effects of experimental and problem solving interventions in resolving marital conflicts. *Journal of Consulting and Clinical Psychology*. 53, 175-184.

Jones, J. C., & Barlow, D. H. (1990) The etiology of posttraumatic stress disorder. *Clinical Psychology Review.* 10, 299-328.

Janoff-Bulman, R. (1992) *Shattered assumptions: Towards a new psychology of traum*a. New York, NY, US: Free Press.

Jorgensen, M. W., & Phillips, L. J. (2002) *Discourse analysis as theory and method*. SAGE Publications Ltd.

Joseph, S., & Linley, P. A. (2004) Positive therapy: A positive psychological theory of therapeutic practice. In P.A Linley., & S. Joseph (Eds.) *Positive Psychology in practice.* 354-368. Hoboken, NJ: Wiley.

Joseph, S., & Linley, P. A. (2005) Positive adjustment to threatening events: An organismic valuing theory of growth through adversity. *Review of General Psychology*. 9, 262-280.

Joseph, S., & Linley, P. A. (2006) Growth following adversity: Theoretical perspectives and implications for clinical practice. *Clinical Psychology Review*. 26, 1041-1053.

Joseph, S., & Linley, P. A. (2008) Psychological assessment of growth following adversity: A review. In S. Joseph & P. A. Linley (Eds.) Trauma, recovery and growth. Positive *Psychological Perspectives on Posttraumatic Stress*. 21-38. Hoboken, NJ: Wiley.

Kaltman, S., Krupnick, J., Stockton, P., Hooper, L., & Green, B. L. (2005) Psychological impact of types of sexual trauma among college women. *Journal of Traumatic Stress.* 18(5), 547-555.

Kashdan, T. B., & Rottenberg, J. (2010) Psychological flexibility as a fundamental aspect of health. *Clinical Psychology Review*. 30, 865-878.

Kazdin, A. E. (2008) Evidence based treatment and practice: New opportunities to bridge clinical research and practice, enhance the knowledge base and improve patient care. *American Psychologist*. 53, 146-159.

Kim, J. S. (2008) Examining the effectiveness of solution focused brief therapy: A meta-analysis. *Research on Social Work Practice.* 18: 107-116.

Kim, J. S. (2014) *Solution-focused brief therapy. A multicultural approach*. SAGE Publications, Inc.

Kim, J. S., & Franklin, C. (2009) Solution-focused brief therapy in schools: A review of the outcome literature. *Children and Youth Services*. 31(4), 464-470.

Kim, J. S., Smock, S., Trepper, T. S., McCollum, E. E., Franklin, C. (2010) Is Solution Focused Brief Therapy Evidence-Based? Clinical Practice Issues. Families in Society: *The Journal of Contemporary Social Services*. 91(3), 300-306.

Kobasa, S. (1982) The hardy personality: toward a social psychology of stress and health. In J. Suls & G. Sanders (Eds.). *The Social Psychology of Health and Illness.* 3-33. Hillsdale, NJ: Erlbaum.

Kok, C. J., & Leskela, J. (1996) Solution-Focused Therapy in a Psychiatric Hospital. *Journal of Marital and Family Therapy*. 22(3), 397-406.

Krupnick, J. L. (2002) Brief Psychodynamic Treatment of PTSD. *Journal of Clinical Psychology*. 58(8). 919-932.

Larkin, M., Watts, S., & Clifton, E. (2006) Giving voice and making sense in interpretative phenomenological analysis. *Qualitative Research in Psychology*. 3, 102-120

Lee, R. M., Draper, M., & Lee, S. (2001) Social connectedness, dysfunctional interpersonal behaviors and psychological distress: testing a mediator model. *Journal of Counselling Psychology*. 48(3), 310-318.

Lee, M. Y., Greene, G. J., Mentzer, R. A., Pinnell, S., & Niles, D. (2001) Solution-focused brief therapy and treatment of depression. A pilot study. *Journal of Brief Therapy*. 1, 33-49.

Lehmann, P., & Patton, J. (2011) The development of a solution-focused fidelity instrument: A pilot study. In C. Franklin., T. S. Trepper., E. E. McCollum., & W. J. Gingerich (Eds). *Solution Focused brief therapy: A handbook of evidence based practice*. 39-54. New York: Oxford.

Lerner, H. G. (1987) Is family systems theory really systemic? A feminist communication. *Journal of Psychotherapy and the Family*. 3(4), 47-63.

Levenson, H. (1995) *Time limited dynamic psychotherapy: A guide to clinical practice.* New York. Basic Books. HarperCollins Publishers Inc.

Levenson, H., Butler, S. F., & Beitman, B. D. (1997) *Brief Dynamic Psychotherapy.* American Psychiatric Press Inc.

Lewis, T. F., & Osborn, C. J. (2004) Solution-Focused Counseling and Motivational Interviewing: A Consideration of Confluence. *Journal of Counseling and Development.* 82(1), 38-48.

Lincoln, Y. S., & Guba, E. G. (1985) *Naturalistic Inquiry*. Beverly Hills. CA:Sage.

Lindforss, L., & Magnusson, D. (1997) Solution Focused Therapy In Prison. *Contemporary Family Therapy.* 19, 89-103.

Linley, A. P., & Joseph, S. (2004) Positive change following trauma and adversity. A review. *Journal of Traumatic Stress*. 17, 11-21.

Linley, A. P., & Joseph, S. (2005) The human capacity for growth through adversity. *American Psychologist*. 60, 262-263.

Lipchik, E. (2002) *Beyond technique in solution focused therapy*. New York: Guilford Press.

Lyddon, W. J. (1998) Social Construction in Counselling Psychology: A Commentary and Critique. *Counselling Psychology Quarterly*. 11(2), 215-222.

Macdonald, A. (2007) *Solution-Focused Therapy: theory, research and practice*. London: Sage.

Martin D. J., Garske, J. P., & Davis, M. K. (2000). Relation of the Therapeutic Alliance with Outcome and other Variables: A Meta- Analytic Review. *Journal of Consulting Clinical Psychology*. 68, 438–450.

McGee, D. R., Del Vento, A., Bavelas, J. B. (2005) An interactional model of questions as therapeutic interventions. *Journal of Marital and Family Therapy*. 31, 371-384.

McKergow, M., & Jackson, P. Z. (2005) *An introduction to solutions focused coaching, consulting and facilitation* (Audio book – CD). Cheltenham: Solutions Books.

McKergow, M., & Korman, H. (2009) Inbetween-neither inside nor outside: The radical simplicity of solution-focused brief therapy. Journal of Systemic Therapies. 28(2), 34-49.

McKergow, M., & Stellamans, A. (2011) Restoring the clients choice of actin. Interaction – *The Journal of Solution Focus in Organizations*. 3, 98-105.

Mcleod, J. (1994). *Doing Counselling Research.* London: Sage.

McLeod, J. (2001) *Qualitative Research in Counselling Psychotherapy*. Sage.

Mikulincer, M., Horesh, N., Eilati, I., & Kotler, M. (1999). The association between adult attachment style and mental health in extreme life–endangering conditions. *Personality and Individual Differences*. 27, 831–842

Miller, G. (1997) *Becoming miracle workers: Language and meaning in brief therap*y. Hawthorne. NY: Aldine de Gruyter.

Miller, S. D. (1994) The solution conspiracy: A mystery in three instruments. *Journal of Systemic Therapies*. 13: 18-37.

Mills, S., & Hulbert-Williams, L. (2012) Distinguishing between treatment efficacy and effectiveness in post-traumatic stress disorder (PTSD: Implications for contentious therapies. *Counselling Psychology Quarterly* 25(3), 319-330.

Mowrer, O. H. (1960) *Learning theory and behaviour*. New York: Wiley.

National Institute Clinical Excellence (2005) *Post-traumatic stress disorder (PTSD): The treatment of PTSD in adults and children.* National Institute Clinical Excellence

Neocleous, M. (2012) "Don't Be Scared, Be Prepared": Trauma-Anxiety – Resilience. *Alternatives: Global, Local, Political*. 37(3), 188-198.

Newnham, E. A., & Page, A. C. (2010) Bridging the gap between best evidence and best practice in mental health. *Clinical Psychology Review*. 30, 127-142.

Nietzche, F. (1998) *Twilight of the idols*. Oxford University Press.

Nolen-Hoeksema, S., & Morrow, J. (1991) A prospective study of depression and posttraumatic stress symptoms after a natural disaster: The 1989 Loma Prieta Earthquake. *Journal of Personality and Social Psychology*. 61, 115-121.

Norum, D. (2000) Brief Therapy: the family has the solution. *Journal of Systemic Therapies.* 19(1), 3-6.

O' Connell, B. (1998) *Solution-Focused Therapy*. SAGE Publications Ltd.

O'Connell, B., Palmer, B., & Williams, H. (2012) *Solution Focused Coaching in Practice*. London: Routledge.

O'Hanlon, B. (1999) *Evolving Possibilities*. Philadelphia, PA: Brunner/Mazel.

O'Hanlon, B., & Wilk, J. (1987) *Shifting contexts: The generation of effective psychotherapy.* New York: Guilford.

Orwin, R. G. (2000) Methodological challenges in study design and implementation. Assessing program fidelity in substance abuse health services research. *Addiction.* 95(3), 309-327.

Pals, J. L., & McAdams, D. P. (2004) The transformed self: A narrative understanding of posttraumatic growth. *Psychological Inquiry*. 15, 65-69.

Park, C. L., Cohen, L. H., & Murch, R. (1996) Assessment and prediction of stress related growth. *Journal of Personality*. 64, 71-105.

Pearlman, L. A., & Saakvitne, K. W. (1995) *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors*. New York, NY, US: W. W. Norton & Co.

Peterson, C. (2006) *A primer in positive psychology*. New York, NY: Oxford University Press.

Prochaska, J. O., & Norcross, J. C. (Eds.) (1999) *Systems of psychotherapy: A transactional analysis* (4th ed). Pacific Grove, CA: Brooks/Cole.

Rachman, S. (1980) Emotional Processing. *Behavior Research & Therapy*, 18, 51-60.

Rogers, C. (1951) *Client centered therapy: its current practice implications and theory.* Boston: Houghton Mifflin.

Roth, A., & Fonagy, P. (2005) What works for whom? Second edition. A critical review of psychotherapy research. *Psychotherapy Research*. Guilford Press.

Rowan, T., & O'Hanlon, W. H. (1999) *Solution-oriented therapy for chronic and severe mental illness.* New York: Wiley & Sons.

Rudes, J., & Guterman, J. T. (2007) The value of social constructionism for the counselling profession: A reply to Hansen. *Journal of Counselling and Development*. 85(4), 387-392.

Ryff, C. D. (1989) Happiness is everything, or is it – explorations on the meaning of psychological wellbeing. *Journal of Personality and Social Psychology*. 57, 1069-1081.

Schottenbauer, M. A., Glass, R., Arnkoff, D. B., & Gray, S. H. (2008) Contributions of Psychodynamic Approaches to Treatment of PTSD and Trauma: A Review of the Empirical Treatment and Psychopathology Literature. *Psychiatry*. 71 (1), 13-20

Segal, H. (1974) *Introduction to the Work of Melanie Klein.* New York, Basic Books.

Seligman, M. E. P., & Csikszentmihalyi, M. (2000) Positive psychology: an introduction. *American Psychologist*. 38, 1161-1173.

Seligman, M. E. P. (2002) *Authentic Happiness*. New York: Free Press.

Shapiro, F. (1989) Efficacy of the eye movement desentization procedure in the treatment of traumatic moments. *Journal of Traumatic Stress*. 2(2), 199-223.

Shapiro, F. (1995) *Eye movement desensitization and reprocessing basic principles, protocols and procedures.* New York: Guilford.

Shapiro, F. (2001) *Eye movement desensitization and reprocessing: Basic principles protocols, and procedures* (2nd Ed). New York: Guilford

Sharry, J., Darmody, M., Madden, B. (2002) A solution-focused approach to working with clients who are suicidal. *British Journal of Guidance and Counselling*. 30: 383-399.

Shennon, G., & Iveson, C. I. (2012) From solution to description. Practice and Research in Tandem. In C. Franklin, T. S. Trepper., W. J. Gingerich., E. E. McCollum. *Solution-Focused Brief Therapy. A Handbook of Evidence-Based Practice.* Oxford University Press.

Shenton, A. K. (2004) Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information*. 22, 63-75

Shoham, V., Rohrbaugh, M., & Patterson, J. (1995) Problem and solution focused couple therapies. The MRI and Milwaukee Models. In N. S. Jacobson., & A. E. Gurman (Eds.). *Clinical Handbook of Couple Therapy*. 142-164. New York: Guilford.

Siegel, D. J. (1999) *The Developing Mind: Toward a Neurobiology of Interpersonal Experience*. New York: Guilford Press, 1999.

Smith, J. A. (1996) Beyond the divide between cognition and discourse: using interpretative phenomenological analysis in health psychology. *Psychology and Health*. 11, 261-271.

Smith, J. A. (2011) Evaluating the contribution of interpretative phenomenological analysis. *Health Psychology Review*. 5(1), 9-27

Smith, J. A., Flowers, & Larkin. (2009) *Interpretative Phenomenological Analysis. Theory, method and research.* Sage Publications Ltd.

Smith, J. A., & Osborn, M. (2003) Interpretative Phenomenological Analysis. In J. A. Smith. (Ed.) *Qualitative Psychology: A practical guide to methods*. London: Sage.

Smucker, M. R. (1997) Post-traumatic stress disorder. In R. L. Leahy (Ed.) *Practising Cognitive Therapy*. 193-220. Northvale, NJ: Jason Aronson.

Snyder, C. R., Rand, K. L., & Sigmon, D. R. (2002). Hope theory: A member of the positive psychology family. In C. R. Snyder & S. J. Lopez (Eds), *Handbook of Positive Psychology*. 257–276. London: Oxford University Press.

Softas-Nall, B. C., & Francis, P. C. (1998) A solution-focused approach to a family with a suicidal member. *The Family Journal: Counselling and therapy for couples and families.* 6, 227-230.

Solution Focused Brief Therapy Research Committee (2015). Retrieved in October 2014 from: *http://www.solutionfocused.net/research/*

Spermon, D., Darlington, Y., & Gibney, P. (2010) Psychodynamic psychotherapy for complex trauma: targets, focus, applications, and outcomes. *Psychology Research and Behavior Management.* 3, 119-127.

Stalker, C., Levene, J., & Coady, N. (*1999*) Solution-Focused Brief Therapy - One Model Fits All? *Families in Society: The Journal of Contemporary Social Services*. 80(5), 468-477.

Stams,G. J., Debovic, M., Buist, K., & De Vries, L. (2006) Efficacy of solution-focused brief therapy: A meta-analysis. *Behavior Therapy*. 39, 81-94.

Strawbridge, S., & Woolfe, R. (2003) Counselling Psychology in Context. In R. Woolfe., W. Dryden., & S. Strawbridge (Eds.). *Handbook of Counselling Psychology*. Second Edition. SAGE Publications.

Stewart, R. E., & Chambless, D. L. (2010). Interesting practitioners in training in empirically supported treatments. Research reviews versus case studies. *Journal of Clinical Psychology*. 66, 73-95.

Stiles, W. B. (1999). Signs and voices in psychotherapy. *Psychotherapy Research*. 9, 1–21.

Stock, W. A. (1994). Systematic coding for research synthesis. In H. Cooper & L. V. Hedges (Eds.), *The handbook of research synthesis* (pp. 125-138). New York: Russell Sage.

Taylor, C. (1985). Self-interpreting animals. W: *Philosophical Papers 1: Human Agency and Language* (s. 45-76). Cambridge: Cambridge University Press.

Taylor, S., Thordarson, D.S., Maxfield, L., Fedoroff, I.C., Lovell, K., & Ogrodniczuk, J.S. (2003). Comparative efficacy, speed, and adverse effects of three PTSD treatments: Exposure therapy, EMDR, and relaxation training. *Journal of Consulting and Clinical Psychology*. 71, 330-338

Tedeschi, R. G., & Calhoun, L. G. (1996) The post-traumatic growth inventory: measuring the positive legacy of trauma. *Journal of Traumatic Stress.* 9, 455-471.

Tedeschi, R. G., & Calhoun, L. G. (2004) Posttraumatic Growth: Conceptual Foundations and Empirical Evidence. *Psychological Inquiry*. 15(1), 1-18.

Tedeschi, R. G., & Calhoun, L. G. (2006) *Time of change? The spiritual challenges of bereavement and loss.* Omega. 53, 105-116.

Tedeschi, R. G., Park, C. L., & Calhoun, L. G. (1998). *Posttraumatic growth: Positive changes in the aftermath of crisis*. Mahwah, NJ: Lawrence Erlbaum Associates, Inc.

Tennen, H. (2013) *Positive change following trauma: controversies and new directions*. Comments presented at the 29th annual meeting of the international society of traumatic stress studies, Philadelphia.

The British Association Counselling Psychotherapy (BACP) (2010) *Ethical Framework for Good Practice in Counselling and Psychotherapy*. Leicestershire: The British Association for Counselling and Psychotherapy.

The British Psychological Society (2009) *Code of Ethics and Conduct*. Leicester: The British Psychological Society.

Tomori, C., & Bavelas, J. B. (2007) Using microanalysis of communication to compare solution-focused and client-centered therapies. *Journal of Family Psychotherapy*. 18(3), 25-43.

Trapnell, P. D., & Campbell, J. D. (1999) Private self-consciousness and the five factor model of personality: distinguishing rumination from reflection. *Journal of Personality and Social Psychology*. 76, 284-304.

Trepper, T. S., Dolan, Y., McCollum, E. E., & Nelson, T. (2008) *Steve De Shazer and the future of solution focused therapy.* 32(2), 133-139

Trepper, T. S., & Franklin, C. (2012) Epilogue. The future of research in solution-focused brief therapy. In C. Franklin., T. S. Trepper., W. J. Gingerich., & E. E. McCollum.

(Eds.) *Solution-Focused Brief Therapy. A Handbook of Evidence Based Practice*. Oxford University Press.

Trepper, T. S., McCollum, E. E., De Jong, P., Korman, H., Gingerich, W. J., & Franklin, C. (2012) Solution-Focused Brief Therapy Treatment Manual. In C. Franklin., T. S. Trepper., W. J. Gingerich., & E. E. McCollum. (Eds.) *Solution-Focused Brief Therapy. A Handbook of Evidence-Based Practice.* Oxford University Press.

Visser, C. F. (2012) *The Solution-Focused Mindset: An Empirical Test of Solution-Focused Assumptions*. Downloaded from: www.solutionfocusedchange.com.

Wachtel, P. L. (1991) From eclectism to synthesis: towards a more seamless psychotherapy integration. *Journal of Psychotherapy Integration*. 45, 709-720.

Walter, J. L., & Peller, J. E. (1992) *Becoming solution-focused in brief therapy*. Levittown, PA: Brunner/Mazel.

Ward, G. (1997) *Understanding Postmodernism*. Hodder Education.

Williams, M. B., & Poijula, S. (2002) *The PTSD Workbook: Simple, effective techniques for overcoming traumatic stress symptoms*. New Harbinger Publications.

Winnicott, D. W. (1949) Hate in the countertransference. *The International Journal of Psycho-analysis,* 30, 69-74.

Winter, G. (2000) A comparative discussion of the notion opf validity in qualitative and quantitative research. *The Qualitative Report.* 4(3&4).

Wittgenstein, L. (1958). *Philosophical Investigations* (translated by GEM Anscombe). Oxford: Blackwell

Zlotnick, C., Johnson, J., Kohn, R., Vicente, B., Rioseco, P., & Saldivia, S. (2008) Childhood trauma in diagnosis: adulthood, and psychiatric results from a community sample. *Comprehensive Psychiatry*. 49, 163-169.

3. APPENDICIES

APPENDIX 1

LETTER GIVING ETHICAL APPROVAL

Date: 7th January 2014

Alyson Griffin

Dear Alyson

Re: Solution Focused Practitioners' experience of facilitating post traumatic growth during brief therapy.

Submitted to the Faculty of Education, Health and Wellbeing Ethics Sub-Committee Board (Health Professions, Psychology & Social Care)

The Faculty Ethics Sub-Committee (Health Professions, Psychology & Social Care) met on 16TH December 2013**.** Your project was considered and reviewed at this meeting.

On review your research proposal was passed and given approval **(Code 2 – Pass (Researcher/Supervisor to Monitor).** You are free to begin your study contingent on addressing any minor amendments detailed below.

Supervisors must ensure the minor amendments have been completed prior to commencement of data collection.

We would like to wish you every success with the project.

Yours sincerely

H Paniagua
Dr. H. Paniagua PhD, MSc, BSc (Hons) Cert. Ed. RN RM Chair –
School Ethics Committee

D Chadwick
Dr. D. Chadwick PhD, MSc, BA (Hons). PGCE Chair –
School Ethics Committee

APPENDIX 2

Sample letter to organisation.

Dear Sir or Madam

I am writing to ask for your support with my doctoral research. I am completing the Doctorate in Counselling Psychology at the University of Wolverhampton, and my thesis exploring the experiences of facilitating post traumatic growth during brief therapy, specifically with therapists using solution focused therapy. Would you be able to refer any potential participants for the study who are trained in solution focused therapy? Although there are no potential benefits of this research for you as a service it is hoped that the experiences of the practitioners' using this approach will help me to understand how and why it is effective with clients who have experienced trauma and also the study may be published, so will benefit those who are using this approach in their working practice. A summary of the main findings will be made available to participants and facilitating organisations.

I am therefore writing to seek your permission to conduct this study in one of your counselling rooms with your Solution Focused Practitioners' and enclose a copy of the research proposal for your information.

I look forward to hearing from you.

Yours sincerely

Alyson Griffin (Trainee Counselling Psychologist)

Contact email address: EMAIL ADDRESS REMOVED

Supervisor details: Dr Wendy Nicholls: EMAIL ADDRESS REMOVED

APPENDIX 3

Sample Letter to participants.

Dear Sir or Madam

As part of my Doctorate course at the University of Wolverhampton, I am proposing to conduct a research project into Solution Focused Practitioners' experiences of facilitating post traumatic growth during brief therapy. To do this I am writing to you to invite you to take part in a semi structured interview about your experience of using solution focused therapy. If you agree to take part this will involve you participating in a 45-90 minute semi-structured interview. Although there are no potential benefits of this research for you personally it is hoped that the experiences of the practitioners' using this approach will help me to understand how and why it is effective with clients who have experienced trauma and also the study may be published, so will benefit those who are using this approach in their working practice. A summary of the main findings will be made available to participants and facilitating organisations.

I am therefore writing to seek your permission to conduct this study in your counselling room where you work and enclose a copy of the participant information sheet for you. Please email me using my contact details below if you would like to know more or register your interest in participating.

I look forward to hearing from you.

Yours sincerely

Alyson Griffin (Trainee Counselling Psychologist)

Contact email address: EMAIL ADDRESS REMOVED

Supervisor details: Dr Wendy Nicholls – EMAIL ADDRESS REMOVED

APPENDIX 4

CONSENT FORM

Title of Project: Solution Focused Practitioners' experiences of facilitating post traumatic growth during brief therapy

Name of Researcher: Alyson Griffin

Please initial boxes

1. I confirm that I have read and understand the information sheet dated …… for the above study and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw prior to the interview taking place, without giving any reason. ☐
3. I understand that my data will be stored securely and confidentially and that I will not be identifiable in any report or publication ☐
4. I understand that the researcher may wish to publish this study and any results found, for which I give my permission ☐
5. I agree for my interview to be tape recorded and for the data to be used for the purpose of this study. ☐
6. I understand that any questionable practice may be shared and taken further if disclosed ☐
7. I agree to take part in the above study. ☐

……	……..	……
Name	Date	Signature
……	……..	……
Name of person taking consent (if different from researcher, state position)	Date	Signature
……	……	……
Researcher	Date	Signature

APPENDIX 5

Participant information sheet

Date:_____ Version number:_____

Study title: Solution Focused Practitioners' experiences of facilitating post traumatic growth during brief therapy.

Invitation paragraph

"*You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with friends/relatives. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this".*

What is the purpose of the study?

The aim is to explore the experiences facilitating post traumatic growth during brief therapy for therapists using solution focused therapy. I want to know why you decided to train in this therapeutic approach and how it has helped you in a therapeutic capacity when working with clients who have experienced trauma, for example, violence, rape and stressful situations. I also want to explore the process underpinning this approach, how it is implemented by you as therapist, what makes it difference and/or similar to the other approaches, how the interventions used help the client and why it can be more helpful in facilitating growth in comparison to problem focused approaches.

You may be aware that there is currently a lack of research focussing on Solution Focused Therapy, particularly in the field of psychology and in relation to post traumatic growth specifically. It is hoped that this research will promote the use of solution-focused therapy in the field of counselling psychology.

The research project should take me one year to complete.

Why have I been chosen?

You have been identified as a suitable candidate for this study because you are using solution focused therapy and have also gained a qualification in this.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form (a copy for me and you). If you decide to take part you are still free to withdraw up until the commencement of

the data analysis. After this point I might not be able to identify your data from the other participants' because it will be anonymised.

What will happen if I decide to take part?

You will be involved in the research for the duration of the semi structured interview which will last approximately 1 hour. You will be asked to take part in a semi structured interview where you will be asked various questions (please see interview questions for an idea of the structure). During the interview a tape recorder/dictaphone will be used, so that I can transcribe the interview once it has finished. This will enable me to analyse the information gained so that I can address the aims of my study. Please answer the questions that I ask as honestly as possible. There is no right or wrong answer, I am simply interested in how you're using solution focused therapy with client who have experienced trauma. If you have any questions or concerns at the end of the interview it is your responsibility to ask me at the time, so that we can clarify things before you leave the room.

What are the potential benefits and risks of taking part?

Though there are no direct benefits for you if you take part, but it will help you to find out about the use of solution focused therapy with psychological trauma and this may help to promote solution focused therapy with clients who have experienced psychological trauma in a general sense. Although the research will not be looking at outcomes of therapy, it will be helpful to know why it works from your perspective, so your input in this research is invaluable.

There are no risks to you in taking part outside of those you would experience in everyday life. However, by taking part, you may remember things that you may find upsetting. If this occurs, the researcher will ask you if you want to continue to participate in the interview. Any decision you make will be respected. Furthermore, if you disclose anything that is deemed questionable practice, then I will have to explore this further with you and pass it on to the relevant people.

Will my taking part in the study be kept confidential?

"Yes. All the information about your participation in this study will be kept confidential. The transcription of the interview you participate in will be stored on a password protected computer in a locked office. The transcript will be anonymised. Only the researchers working on the project and the examiner will have access to the information. You will not be identifiable in any publication or report as the data will be grouped together and all identifying information will be removed."

What will happen at the end of the research study?

The findings obtained from the study can be made accessible to participants if they would like a summary of these and can be requested via my email address: EMAIL ADDRESS

REMOVED. If the research is published then a copy of this can be accessed and participants will be directed to this link at time of completion.

What if I have a problem or concern?

"If you have a concern about any aspect of this study, you should ask to speak with the researchers who will do their best to answer your questions" or please do not hesitate to contact my research supervisor: Dr Wendy Nicholls. Her email address is: EMAIL ADDRESS REMOVED

Who has reviewed the study?

Health professions, Psychology, Social Care & Social Work Ethics committee for the Faculty of Education, Health & Wellbeing, University of Wolverhampton.

Contact for further information

As suggested previously please do not hesitate to contact my research supervisor: Dr Wendy Nicholls – EMAIL ADDRESS REMOVED.

I would also like to take this opportunity to thank you for agreeing to take part in my study.

Alyson Griffin (Trainee Counselling Psychologist)

Contact email address: EMAIL ADDRESS REMOVED

APPENDIX 6:

DEMOGRAPHIC SHEET

Title of Research Project:

Solution Focused Practitioners' experiences of facilitating post traumatic growth during brief therapy

Participant Code: _____

Please fill in the following details:

1.Male/Female : _____

2. Age:_____ _____

3. Number of years practising as a therapist:

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 10+ ☐

4. Number of years practising solution focused therapy

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 10+ ☐

5. Therapeutic orientation:_____

6. Current places of work – e.g. hospital, private practice:

_____ _____

7. Work experience prior to the current role(s) stated above:

_____ _____

_____

APPENDIX 7

Participant Debriefing Information Sheet

Project Title:

Solution Focused Practitioners' experiences of facilitating post traumatic growth during brief therapy.

Researcher: Alyson Griffin (Trainee Counselling Psychologist)

Participant ID number:

This research aimed to explore Solution Focused Practitioners'' experiences of facilitating post traumatic growth during brief therapy. Having participated in this study, your contribution will give an insight into the experience of using solution focused therapy to help clients to overcome psychological trauma. The process of analysis will identify themes in the data collected from all participants through the use of Interpretive Phenomenological Analysis. Phenomenology is concerned with the ways in which human beings gain knowledge of the world around them. IPA will therefore capture the quality and texture of individual experience (Willig, 2001).

If you would like to be informed about the outcome of this research, which is due for completion in August 2015, then please let the researcher know so that a Summary Report can be prepared for you. For later requests contact the researcher directly: EMAIL ADDRESS REMOVED

If you have any queries regarding this study that you feel the researcher cannot assist, you are welcome to contact: Dr. Wendy Nicholls – EMAIL ADDRESS REMOVED

APPENDIX 8

Possible interview questions

Solution Focused Practitioners' experiences of facilitating Post Traumatic Growth during brief therapy.

(Please note that this is a selection of questions which will guide the interview, it may be that all questions and prompts are not used for all participants. It will depend on the nature of the interview.)

Experiences of using this approach – how many years have you been practising? How many clients (percentage would you say you have helped using Solution Focused Therapy?)

Where did you train? Where did you study Solution Focused Therapy?

How do you decide which clients are suitable for Solution Focused Therapy?

Other experience – what did the other training course you complete miss which you hoped to fill with Solution Focused Therapy?

What is your understanding of trauma when working with clients?

Prompt: What does it range from and to?

What is the client's definition of trauma? Is it different to your own perception?

What is your understanding of post traumatic growth? –

Prompt: Can you give an example of a time you have experienced post traumatic growth with a client? – What techniques did you use to foster client determination and resilience?

What is it about Solution Focused Therapy that helps a client to overcome trauma?

Prompt: How have you found working with clients who have experienced trauma?

What changes have you noticed in your client work since using Solution Focused Therapy? Can you share a client case study where you helped a client to overcome trauma using Solution Focused Therapy? – When, how many sessions? What exercises worked best? What informed your practice? How did you feel? What happened?

What techniques have been unsuitable/didn't work/were difficult to implement? Can you give an example of when it didn't work and why?

What typical outcomes do you experience with a client when using solution focused therapy?

Prompt – specifically when facilitating post traumatic growth

How do clients maintain post traumatic growth post therapy?

Have clients returned to you – if so, why/what changed?

What impact has working with trauma had upon you?

Prompt - Has working from a solution focused standpoint changed your approach to life? What have the wider implications been of using this approach?

- Personal life
- Choices/career

What are the wider applications for practice in the field of Counselling Psychology?

APPENDIX 9 – TABLE SHOWING CLUSTERING PROCESS FOR ALL PARTICIPANTS

Superordinate theme: Who am I? – becoming solution focused

Key for sub-themes:
(1) Self-discovery – what was missing?
(2) The evolvement of the therapist
(3) Values and beliefs – the underpinning philosophy
(4) Knowing it works – application of the approach on a personal level

Participant	**Themes** (numbers in the closed brackets are linked to the above sub-themes)
Participant 1 (Lucy)	**The solution focused practitioner** • Is educated to a high level and academic (2) • A desire to search for new insights and meaning – something was missing from previous training (1) • Values and beliefs are the foundations for therapy (3) • Philosophical views are the bedrock for therapy (3) • The practitioner is accepting of clients and works from a non-judgemental stance (3) • Impact of approach on self-rewarding (4)
Participant 2 (John)	**Who am I** • Background influence (1) • Fits with self – a way of being (1/2) • The value of life (3/4) • Attachment – secure base (3)
Participant 3 (Ben)	**The Practitioner** • Where it began – the roots of therapy (1) • Influence – idols inspiring new meaning (1) • Experience/evolvement forming professional identity (2) • Personal philosophy – knowing it works (3/4)

Participant 4 (Matt)	**Becoming Solution Focused –** • Evolvement (2) • Challenged outlook on life – therapist and client (1/4) • Influence of training (1/2) • Influence of supervision (2) • Process of learning (2) • Sharpened focus (2) • Philosophy – social constructionism – how we construct our realities (3)
Participant 5 (Chris)	**A personal journey** • Background influences (1) • Belief systems (3/4) • Identity shaped by context/clients (2) • Experience (2/4)
Participant 6 (Victoria)	**Identity** • Status of the practitioner – experience (2) • Emotional tightrope (2) • Basis/grounding (1) • Fits personality and belief in others (1/3) • Lightbulb moments (4)

Superordinate theme: A problem world where trauma exists

Key for sub-themes:

(1) Making sense of it through experience – it is in the eye of the beholder

(2) Use of problem language and labels categorise

(3) The position of the client - agenda

(4) The trauma identity

Participant	**Themes** (numbers in the closed brackets are linked to the above sub-themes)
Participant 1 (Lucy)	**Trauma** • Relative/perception (1) • Reality/problem world (1) • Agenda of client relating to expectations (3) • Labels – diagnostic (Cause and effect) (2) • Trauma ID/world (4)
Participant 2 (John)	**Making sense of trauma** • What is it? – notion of trauma (1) • Experiences are on a spectrum (1) • Acceptance of loss (3/4)
Participant 3 (Ben)	**Notion of trauma** • Societal shift (1) • At the root of the matter (1) • Use of discourse/language (2) • Systems and typologies (4) • The position of the client – how much do they want to move on (3)
Participant 4 (Matt)	**Notion of trauma** • Therapist understanding (1) • Client agenda (3) • Use of labels (2) • Trauma ID (4)

Participant 5 (Chris)	**A problem world** • Making sense of trauma (1) • Use of language (2) • Trauma ID (4)
Participant 6 (Victoria)	**A notion of trauma** • Understanding of what it means (1) • Use of language (2) • Client agenda – acceptance (3)

Superordinate theme: A positive cocoon where growth can occur

Key for sub-themes:
(1) A different lens – a change in perspective
(2) The co-construction of a new reality through language – connected conversations
(3) Building resilience through positivity and optimism – the survival instinct
(4) How much do they want to move on – maintenance of growth

Participant	**Themes** (numbers in the closed brackets are linked to the above sub-themes)
Participant 1 (Lucy)	**The solution focused magic** • One size-fits-all – therapeutic ethos (1) • It has the power to change way of thinking and being (1/2) • The use of discourse/language as a catalyst for change (2) **How does it work** – the use of interventions (2)
	Growth/maintenance • Movement through interaction (2) • Different perception (1) • Building life away from problem – resilience (3) • Validation of the clients inner resources/strength (3) • Proactive – client becomes agent of change (4)

Participant 2 (John)	**Offers something more – the magic behind the approach** • Acceptance of self and others – awareness of difference (1) • Recovery through interaction – co-construction (2)
	Client growth and movement • Empowerment (3) • Building resilience (3) • Use of language/narrative (2) • Inner strength – overcoming defences (3) • Coping – validation (1) • Building relationships (4)
Participant 3 (Ben)	**The position of the client** • Outcomes/moving on (2/3/4) • Growth (4)
Participant 4 (Matt)	**Promoting growth** • Moving on (4) • Empowerment (3) • Embracing SFBT (1/2) • New way of being (1)
Participant 5 (Chris)	**A Positive cocoon** • Client takes an active role, therapist takes a back seat (1) • A way of being (4) • Making a difference (2/3) • Recovery through resilience (3) • Growth - connected conversations (2)
Participant 6 (Victoria)	**Ethos of SFBT** • A different lens/way of being (1) • Empowering - growth (4) • Reconnect – relationships (1) • Resilience (3) • Optimistic perspective (3) • Normalising the experience (3)

	The SFBT client and how they respond to therapy • Building on resilience (3) • Movement – a life beyond (2)

Superordinate theme: The Longevity of the approach – a small fish in a big pond

Key for sub-themes:
(1) Spreading the word
(2) Striving for acceptance
(3) Moving with the times – a growing need for brief therapy
(4) The potential pitfalls of the approach

Participant	**Themes** (numbers in the closed brackets are linked to the above sub-themes)
Participant 1 (Lucy)	**Fighting for survival** • Therapy doesn't have to be long term (3) • Application in reality (1) • Purist approach versus an integrative approach (4)
Participant 2 (John)	**The longevity of the approach** • Moving with the times (3) • Outcomes and evidence (4) • Hierarchy – power and control (2) • Pitfalls (4)
Participant 3 (Ben)	**Small fish in a big pond** • Fighting for survival (1/2) • Power-less – negativity (2) • Spreading the word (2) • Different philosophical standpoints (4) • Lack of formal training (4)

Participant 4 (Matt)	**The future of SFBT** • Training needs (2) • Specialised work (1) • Pitfalls of the approach (4) • Integration (2) • A growing need for brief therapy (3)
Participant 5 (Chris)	**The longevity of SFBT** • The poor relation (2) • Spreading the word (1) • Solidarity – protective of approach (4)
Participant 6 (Victoria)	**Approach with caution** • Quick results (3) • In experience – timely application (4)

APPENDIX 10

Guidelines for trauma-focused psychological treatment (NICE, 2005, P.4)

- 'Trauma-focused cognitive behavioural therapy should be offered to those with severe post-traumatic symptoms or with severe PTSD in the first month after the traumatic event. These treatments should normally be provided on an individual outpatient basis.'
- 'All people with PTSD should be offered a course of trauma-focused psychological treatment (trauma-focused cognitive behavioural therapy [CBT] or eye movement desensitisation and reprocessing [EMDR]). These treatments should normally be provided on an individual outpatient basis'.

Children and young people

- 'Trauma-focused CBT should be offered to older children with severe post-traumatic symptoms or with severe PTSD in the first month after the traumatic event'.
- 'Children and young people with PTSD, including those who have been sexually abused, should be offered a course of trauma-focused CBT adapted appropriately to suit their age, circumstances and level of development'.

APPENDIX 11 – DIAGNOSTIC INFORMATION FOR PTSD

'Diagnostic criteria for PTSD include a history of exposure to a traumatic event that meets specific stipulations and symptoms from each of four symptom clusters: intrusion, avoidance, negative alterations in cognitions and mood, and alterations in arousal and reactivity. The sixth criterion concerns duration of symptoms; the seventh assesses functioning; and, the eighth criterion clarifies symptoms as not attributable to a substance or co-occurring medical condition' (American Psychiatric Association, 2013).

Criterion A: stressor: The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, as follows: (one required)

1. Direct exposure.
2. Witnessing, in person.
3. Indirectly, by learning that a close relative or close friend was exposed to trauma. If the event involved actual or threatened death, it must have been violent or accidental.
4. Repeated or extreme indirect exposure to aversive details of the event(s), usually in the course of professional duties (e.g., first responders, collecting body parts; professionals repeatedly exposed to details of child abuse). This does not include indirect non-professional exposure through electronic media, television, movies, or pictures.

Criterion B: intrusion symptoms : The traumatic event is persistently re-experienced in the following way(s): (one required)

1. Recurrent, involuntary, and intrusive memories. Note: Children older than six may express this symptom in repetitive play.
2. Traumatic nightmares. Note: Children may have frightening dreams without content related to the trauma(s).
3. Dissociative reactions (e.g., flashbacks) which may occur on a continuum from brief episodes to complete loss of consciousness. Note: Children may re-enact the event in play.
4. Intense or prolonged distress after exposure to traumatic reminders.
5. Marked physiologic reactivity after exposure to trauma-related stimuli.

Criterion C: avoidance - Persistent effortful avoidance of distressing trauma-related stimuli after the event: (one required)

1. Trauma-related thoughts or feelings.
2. Trauma-related external reminders (e.g., people, places, conversations, activities, objects, or situations).

Criterion D: negative alterations in cognitions and mood - Negative alterations in cognitions and mood that began or worsened after the traumatic event: (two required)

1. Inability to recall key features of the traumatic event (usually dissociative amnesia; not due to head injury, alcohol, or drugs).
2. Persistent (and often distorted) negative beliefs and expectations about oneself or the world (e.g., "I am bad," "The world is completely dangerous").
3. Persistent distorted blame of self or others for causing the traumatic event or for resulting consequences.
4. Persistent negative trauma-related emotions (e.g., fear, horror, anger, guilt, or shame).
5. Markedly diminished interest in (pre-traumatic) significant activities.
6. Feeling alienated from others (e.g., detachment or estrangement).
7. Constricted affect: persistent inability to experience positive emotions.

Criterion E: alterations in arousal and reactivity- Trauma-related alterations in arousal and reactivity that began or worsened after the traumatic event: (two required)

1. Irritable or aggressive behaviour
2. Self-destructive or reckless behaviour
3. Hypervigilance
4. Exaggerated startle response
5. Problems in concentration
6. Sleep disturbance

Criterion F: duration - Persistence of symptoms (in Criteria B, C, D, and E) for more than one month.

Criterion G: functional significance - Significant symptom-related distress or functional impairment (e.g., social, occupational).

Criterion H: exclusion- Disturbance is not due to medication, substance use, or other illness.

Specify if: With dissociative symptoms.

In addition to meeting criteria for diagnosis, an individual experiences high levels of either of the following in reaction to trauma-related stimuli:

1. Depersonalization: experience of being an outside observer of or detached from oneself (e.g., feeling as if "this is not happening to me" or one were in a dream).
2. Derealization: experience of unreality, distance, or distortion (e.g., "things are not real").

Specify if: With delayed expression.

A full diagnosis is not met until at least six months after the trauma(s), although onset of symptoms may occur immediately.